ARIZONA DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

INSTRUCTION GUIDE

FOR THE

ASSESSMENT, SERVICE PLAN

AND ANNUAL UPDATE

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INTRODUCTION

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) supports a model for intake, assessment, service planning and service delivery that is strength-based, family friendly, culturally sensitive, clinically sound and supervised. The model is based on three equally important components: 1) input from the person and family/significant others regarding their special needs, strengths and preferences; 2) input from other individuals who have integral relationships with the person; and 3) clinical expertise.

In addition, there are six basic principles that serve as a framework for the process of assessment and service plan development. These include ensuring that behavioral health assessments and service plans:

- Are developed with an unconditional commitment to those enrolled in the behavioral health system and their families;
- Begin with empathetic relationships that foster ongoing partnerships and an expectation of equality and respect throughout the service delivery system;
- Are developed collaboratively with families to engage and empower their unique strengths and resources;
- Include other individuals important to the person;
- Are individualized, strength-based, culturally appropriate, and clinically sound; and
- Are developed with the expectation that the person is capable of positive change, growth and leading a life of value.

In order to support this approach, ADHS/DBHS has developed standardized tools to be used by the Tribal/Regional Behavioral Health Authorities (T/RBHAs) and providers when conducting assessments, developing service plans and conducting annual updates on persons enrolled in the ADHS/DBHS behavioral health system. These standardized tools include:

- ADHS/DBHS Behavioral Health Client Cover Sheet
- Assessment and Service Plan Checklist
- Behavioral Health and Medical History Questionnaire
- Core Assessment
- Addenda
- Behavioral Health Service Plan
- Annual Behavioral Health Update and Review Summary

The purpose of this instruction manual is to provide practitioners (i.e., clinical supervisors, assessors and/or clinical liaisons) with an in-depth understanding about how to effectively and efficiently put these tools to use. To this end, the guide addresses the purpose of each component of the tools along with the intent of individual questions. For individual assessment-related questions, examples of additional probes are provided that assessors may choose to use to solicit information.

In addition to this instruction manual, information regarding the assessment, service planning and annual update process can also be found in the ADHS/DBHS Provider Manual, ADHS/DBHS policies and procedures, ADHS/DBHS Covered Behavioral Health Services Guide, and the CIS Instruction Manual. All of these documents can be found on the ADHS/DBHS web site (www.azdhs.gov/bhs).

ASSESSMENT TOOL

General Information

The overall assessment tool is made up of three component parts:

I. **Behavioral Health and Medical History Questionnaire** that is completed by the person/family prior to the initial assessment interview, if possible, or by the assessor during the initial interview and provides the assessor with information about current and past behavioral health and medical issues and services the person is receiving or has received to address these issues.

II. **Core Assessment** that is completed at the initial assessment interview and focuses on collecting enough information to get the person to the appropriate next service(s). If some part of the Core Assessment cannot be completed at the initial appointment (e.g. crisis situation), this should be documented on the Assessment and Service Plan Checklist and the section flagged to complete some time within the next 45 days.

III. **Addenda** that may be completed at a follow-up meeting(s) and facilitate the building of a complete picture of the person/family by further identifying strengths and additional supports through the examination of other life domains.

While the assessment tool has been designed to apply to any population seeking behavioral health services (e.g., adults, children, persons with serious mental illness), addenda have been developed for specific population groups (e.g., SMI Determination, Developmental History, Child Protective Services). Trigger questions lead the assessor to complete additional questions specific to those populations. For example, if there is an indication that a person has a substance related disorder, the assessor would complete a series of more in-depth questions related to current and past substance use. In addition, the assessor may be required to use different probe questions for different populations.

Although the questions were carefully crafted to be strengths-based and engaging, they are open to further levels of inquiry and their wording serves as a guide rather than a rigid formula. The questions focus on identifying gaps in coping, perception, medical need, abuse and/or addiction, or psychological functioning, and determining the internal and external supports, community services, generic services and covered services which may assist a person/family in using all available resources to take charge of their own lives. The assessment tool encourages an ongoing process of implementing and revising clinical services, case management services, support services and medical services; and continual assessment, re-evaluation, clarification and identification of the person's strengths and needs.

In spite of their ongoing nature, T/RBHAs and their providers are expected to complete the initial assessment on persons entering the system within 45 days from the date of their initial intake/ assessment appointment. All demographic data must be submitted to ADHS/DBHS within 45 days of the intake appointment.

Behavioral Health Client Cover Sheet

Prior to the initial assessment interview, the intake worker should, if necessary, assist the person in completing the Behavioral Health Client Cover Sheet (see Appendix A). The purpose of the Cover

Sheet is to record the special needs, key contacts and insurance coverage of the person seeking behavioral health services. Additional information such as other key contacts may be added later to the Cover Sheet by the assessor based on discussions with the person/family during the assessment interview.

Assessment and Service Plan Checklist

At the end of the initial assessment interview, the assessor must complete the Assessment and Service Plan Checklist (see Appendix B). The purpose of the Checklist is to record which components of the assessment were completed at the initial assessment interview. If not completed at the initial interview, the assessor should indicate which additional Addenda will be completed at a later date or are not applicable. In most cases the Service Plan will be completed during subsequent meetings following the initial assessment interview. However, if the Service Plan is completed at the initial appointment, the assessor should so indicate on the Assessment and Service Plan Checklist.

The assessor completing the initial assessment interview should sign the bottom of this Checklist, along with the behavioral health professional reviewer, if the assessor is not a behavioral health professional. For any Addenda and/or Service Plan that are completed at a later date, the assessor completing those sections must individually sign the documents completed.

If the assessment is being completed via telemedicine, the person/family member should affix his/her original signature on the forms where appropriate. The behavioral health practitioner accompanying the person should note on the appropriate lines requiring the assessor's signature (e.g., Mary Smith, certified professional counselor, via telemedicine and initial. At the clinician's site, the assessor should include a statement in his/her progress notes "assessment completed via telemedicine for the following sections of the assessment….." and sign the progress note to complete the documentation process.

In addition to the assessor's signature, it is important for the assessor to complete the client identifying information on the top of the Checklist along with filling in the person's name on the top of each page of the assessment tool.

Supervisor's Assessment and Service Plan Review Standard

In order to ensure that T/RBHAs and providers are conducting assessments and developing service plans which meet ADHS/DBHS standards, ADHS/DBHS has developed the Supervisor's Assessment and Service Plan Review Standard (see Appendix C). This document sets forth the standards that ADHS/DBHS will use when it conducts case file reviews. It is being provided here as part of this instruction manual so that assessors can clearly understand what the expectations are for completion of Assessments and Service Plans as well as to serve as a guide for clinical supervisors to use when reviewing assessor's work.

BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

The purpose of the Behavioral Health and Medical History Questionnaire is to collect information about 1) a person's current and past medical concerns and treatment and 2) any prior behavioral health services the person and his/her family has received or is currently receiving. In order to formulate a comprehensive understanding of the behavioral health needs of any person, his/her past and current behavioral health history and that of his/her family must be explored. Health concerns may not only impact but may also mimic behavioral health disorders, and treatments offered may effect behavioral health treatment in ways that must be thoroughly explored. Referrals to a primary care physician (PCP) must be considered whenever concerns about these issues arise.

The Questionnaire should be provided to the person and/or his/her family prior to conducting the Core Assessment. The assessor will then review the completed Behavioral Health and Medical History Questionnaire with the person/family during the Core Assessment, verifying information and clarifying any items that are unclear. If the person does not have the opportunity or is unable to complete the Questionnaire prior to the interview, the assessor must complete the Questionnaire as part of the Core Assessment.

Specific Behavioral Health and Medical History Questions

1. Are you currently taking any **medications** (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)?
   - □ No, go to question 2.
   - □ Yes, answer questions 1(a) - 1(e) below.

   1(a) Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below. (Name of Medication and Reason for Taking Medication)

Intent:
Many "alternative medications/remedies" and over- the-counter medications can interfere with prescribed medications, and can cause serious side effects and/or a life- threatening situation when combined with traditional medications. A comprehensive profile of all medications and remedies must be developed.

1(b) Have any of your medications been changed in the last month? □ No □ Yes**,** list the medications that have changed and explain why they were changed.

Intent:
To identify medications that may not have been effective and the signs and symptoms the person was experiencing on these medications before the medications were changed.

Possible Probing Questions:
What were the names of the medications that you were taking before your doctor discontinued these medications and prescribed new medication?
Did your doctor tell you why he was changing the medication?

Can you describe how you were feeling before the medications were changed?
Are you feeling better on the new medications?

1(c) How long will your current supply of medications last? (How urgent is your need to obtain medications?)

Intent:
The current supply of medications must be considered when "Next Steps" are developed. A person, who is going to run out of medication soon, should be considered in need of an urgent psychiatric appointment.

Possible Probing Questions:
Do you have enough medication to last until your next scheduled appointment?
Do you have any refills?

1(d) Describe any side effects that you find troublesome from any of the medications you are currently taking.

Intent:
The presence or absence of side effects must be reviewed and considered when assessing compliance issues, appropriateness of current treatment, and time frames for follow up psychiatric appointments.

Possible Probing Questions:
Please describe any problems you are having as a result of taking these medications?
Does the medication impact your ability to perform day-to-day activities or interfere with your life in any way?

1(e) Do you have any abnormal/unusual muscle movements? □ No □ Yes, how is it being treated

Intent:
Persons on certain medications are at risk of developing known movement disorders such as extrapyramidal symptoms, pseudoparkinsonism, akathisia, or tardive dyskinesia. Medications commonly prescribed to counteract these side effects frequently have side effects of their own, complicating and distorting the clinical picture.

Possible Probing Questions:
Do you have any symptoms such as stiff muscles, tremors, drooling, inner restlessness, constant leg movements, jerky movements or neck tightness?
If so, have you been prescribed any medication to help decrease these uncomfortable symptoms and has this medication worked?

2. Are you **allergic** to any medications? □ No □ Yes, which ones?

Possible Probing Questions:
What are the names of the medications that you are allergic to?
What happens when you take this medication? Do you get a rash, do you get short of breath, experience itching, experience any type of swelling, etc.?
Do you carry any identification with you that identifies what medication(s) you are allergic to?

3. Do you have any other **allergies**? □ No □ Yes, describe them.

Possible Probing Questions:
Do you ever experience any symptoms such as shortness of breath, wheezing, coughing, running nose, itching, skin rash, etc.?
Do you take any medications for these allergies?
Have you ever had to go to the emergency room from getting very sick from a bee sting, insect bite, or difficulty breathing?

4. When was the last time you saw your **primary care physician/dentist** and what was the purpose of that visit?

Intent:
To ensure the person is receiving medically necessary services and if needed, a referral or plan is developed to assist the person. Also, additional medical records may need to be requested.

Possible Probing Questions:
Did you see your primary care physician (PCP)/dentist or some other health care provider for a routine check-up or for a special problem?
If you were having a medical problem, did you see your PCP again for a follow up appointment?
Are you seeing any other health care providers for medical problems?
Have you recently gone to urgent care or the emergency room for any problems and, if so, what was the problem you were experiencing?

5. Do you have any history of **head injury** with concussion or loss of consciousness?
□ No □ Yes, describe.

Intent:
The history of a head injury may indicate the need for further assessment or require records be requested from previous service providers. Information relating to the person's status before the injury can assist in distinguishing psychiatric conditions from the effects of head trauma. Referrals to a PCP may be triggered by these inquiries.

Possible Probing Questions:
How did the injury happen? How old were you?
Did you have to go to a hospital for treatment?

Do you know if you lost consciousness?

6. Are you currently **pregnant**? □ No □ Yes □ Unsure

Intent:
Early identification of pregnancy is essential to appropriate service provision and risk assessment. Pregnancy presents additional concerns when the person is abusing substances, may require psychotropic medication, or has symptoms that may reflect a pregnancy-related behavioral health disorder. A pregnant person who is not receiving prenatal health care should be referred to a PCP.

Possible Probing Questions:
If the person answers yes, ask:
Are you seeing a doctor (or some type of health care practitioner) about your pregnancy?

If the person answers unsure, ask:
Have you missed a menstrual period?
Are you experiencing any symptoms of pregnancy? For example, are you experiencing any nausea, weight gain or vomiting?

7. Are there any **medical problems** that you are currently receiving treatment for?
□ No, go to question 8.
□ Yes, answer 7(a) and 7(b) below.

7(a) Describe below what current medical problems you have and what type of treatment you are currently receiving. (Medical Problem and Type of Treatment Receiving)

7(b) Does your current medical condition(s) create problems in how you deal with life, including pain? □ No □ Yes, if yes explain.

Intent:
To identify any physical health problems that need further assessment, referral, coordination and/or medical conditions that may be adversely contributing to or causing behavioral health dysfunction.

Possible Probing Questions:
Can you explain how you are taking care of your present medical condition on a day-to-day basis?
Are you seeing a doctor or some other type of health care practitioner for this medical condition on a regular basis?
Please describe the pain. Is it burning, dull, heavy feeling, sharp, or pressure feeling? What helps the pain? Is the pain constant or just some of the time? What makes the pain worse?

8. Have you recently experienced any of the following?

Intent:
The symptoms outlined below may reflect a behavioral health disorder, a medical problem, a combination of both, or an adverse reaction to medications. Any positive responses to the list below should lead to a PCP referral, a pre-referral consult with psychiatrist or a formal referral for psychiatric services.

Ear/Nose/Throat:

Severe dry mouth	□ No	□ Yes, when _____
Ear infections	□ No	□ Yes, when _____
Persistent sore throat	□ No	□ Yes, when _____

Respiratory System:

Respiratory infections	□ No	□ Yes, when _____
Persistent cough	□ No	□ Yes, when _____
Shortness of breath	□ No	□ Yes, when _____

Cardiovascular:

Chest pain	□ No	□ Yes, where _____
Swelling in legs, ankles, feet	□ No	□ Yes, where _____

Gastro-intestinal:

Persistent nausea / vomiting	□ No	□ Yes, when _____
Self-induced vomiting	□ No	□ Yes, when _____
Frequent or prolonged diarrhea / constipation	□ No	□ Yes, when _____
Excessive use of laxatives	□ No	□ Yes, when _____
Weight loss / gain	□ No	□ Yes, when _____
Blood in stools	□ No	□ Yes, when _____
Abdominal pain	□ No	□ Yes, when _____

Genitourinary:

Urinary discomfort	□ No	□ Yes, when _____
Frequent urination	□ No	□ Yes
Blood in urine	□ No	□ Yes, when _____

Musculoskeletal:

Joint pain	□ No	□ Yes, when _____
Back pain	□ No	□ Yes, when _____

Neurological:

Facial or muscle twitching/jerking	□ No	□ Yes, when _____
Seizures	□ No	□ Yes, when _____
Passing out	□ No	□ Yes, when _____
Dizziness	□ No	□ Yes, when _____
Headaches	□ No	□ Yes, when _____

Infectious Diseases:

Sexually Transmitted Diseases	□ No	□ Yes, when _____ what_____

Other:

Inappropriate defecation (bowel elimination)	□ No	□ Yes, when _____

Inappropriate bed wetting	□ No □ Yes, when _____
Dry skin	□ No □ Yes, when _____
Hair loss	□ No □ Yes, when _____
Unusual sweats or chills	□ No □ Yes, when _____
Surgeries	□ No □ Yes, when _____what _____
Problem with sleeping	□ No □ Yes, indicate more or less sleep _____

Other conditions not listed above (signs and symptoms)

_____
_____
_____
_____
_____

9. Do you **use tobacco**? □ No □ Yes, how much per day? How long have you been using tobacco?

Intent:
Tobacco use is a well-known health risk and is frequently used to self medicate in response to behavioral health symptoms (like anxiety) or the adverse effects of medications such as Extrapyramidal Symptoms (EPS). Although treatment of chronic use has been delegated to the AHCCCS Health Plans, the assessor should approach it with the same concern as any addictive process. As such, if the person is using tobacco, referrals to a cessation program and/or PCP may be indicated.

10. Do you consume **caffeine**? □ No □ Yes, how many cups/cans do you drink per day?

Intent:
Excessive caffeine use can both mimic and accentuate behavioral health symptoms (like anxiety, hyperactivity and sleep disorders) and can therefore confuse the clinical picture. Excessive use can influence a person's tolerance to medication and the effectiveness of medication. The assessor needs to take this fact into consideration when evaluating the person's symptoms.

11. In total, how much **fluid** do you drink, i.e., how many cups/cans of total fluids do you drink per day?

Intent:
Both excessive and limited fluid intake can have adverse effects of a person's physical and behavioral health functioning and can interfere with the safety and effectiveness of certain medications.

12. Have you **ever received out-patient** (office-based) **services**, been **hospitalized** or received services in a **residential facility** for **behavioral health concerns**?

□ No, go to question 13.
□ Yes, answer questions 12(a) – 12(c).

12(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment. (Type of Treatment and When and Where Received)

12(b) What current or prior treatment/services, including medication, do you think have been the most helpful in addressing your behavioral health symptoms? Explain.

12(c) What current or prior treatment/services, including medication, do you think have been the least helpful in addressing your behavioral health symptoms? Explain.

Intent:
To explore from the person's perspective what has worked in the past and what has not been helpful. This information can help determine the preferences of the person and family, the services most likely to be successful and those with the greatest likelihood for compliance. These questions provide an opportunity to engage the person/family and identify successful interventions collaboratively.

Possible Probing Questions:
What behavioral health services and medications were you receiving that made you feel better (or worse)?
Which behavioral health services that you were getting, were the most/least helpful?

13. Describe any current or past **behavioral health issues** (including substance abuse) in your **family.** (*For purposes of this question family may include birth family, adopted family, foster family and/or family person is or has lived with.)*

Intent:
By exploring the family behavioral health history the assessor helps identify the presence of likely familial, genetic and environmental influences. It may also bring to light potential barriers related to family dysfunction that will need to be addressed as treatment progresses.

Possible Probing Questions:
Has anyone in your family been treated at a counseling center or by a psychiatrist? If so, who and what treatment did they get?
Is there anyone in your family who has had similar symptoms or has sought help from a counselor, support group, traditional healer, pastor/priest etc?

If the person seeking behavioral health services was provided assistance in filling out this questionnaire, please provide the name, date of completion and telephone number of the individual providing this assistance.

Name (please print) _____ Date _____ Phone _____

Intent:
When assistance is provided in filling out the questionnaire, it is important to be able to contact the person providing assistance if questions arise or clarification is needed.

CORE ASSESSMENT

Although the assessment process is an ongoing and dynamic one and continues throughout the individual's duration of care, the assessor should in most cases complete the Core Assessment at the initial assessment interview. Two possible exceptions would be 1) a crisis situation where the assessor must first focus on resolving the immediate crisis and 2) 24 hour urgent response for children removed from the home by Child Protective Service (CPS). In these situations while the assessor should try and complete as much of the Core Assessment as possible, it may mean that some sections of the Core Assessment are completed at the next appointment. (See Addendum: Child Protective Services for more specific information regarding requirements associated with urgent response to CPS removal cases.)

The Core Assessment is designed with a limited focus and specific goals, allowing the ongoing evaluation as it progresses to create a more comprehensive portrait of needs and strengths. It is meant to explore only information relative to immediate risks and needs, the development of a meaningful clinical team, and the determination of what the next service needs to be. Besides serving to engage and support the individual and family, the Core Assessment in essence fulfills a triage role, determining the next appropriate clinical steps, when and how those steps will be implemented, and by whom. Additional Addenda, completed over time, augment the content of the Core Assessment.

The Core Assessment is sub-divided into the following nine sections:

- Presenting Concern
- Behavioral Health and Medical History
- Criminal Justice
- Substance Related Disorders
- Abuse/Sexual Risk Behavior
- Risk Assessment
- Mental Status Exam
- Clinical Formulation and Diagnoses
- Next Steps/Interim Service Plan

For each of the Core Assessment sections, a brief statement regarding the purpose of the specific section is provided below. To further assist the assessor, the intent of most questions and opportunities to further probe and elaborate are also provided.

Core Assessment: Presenting Concern

Purpose

The section on Presenting Concern begins the Core Assessment. It is designed to elicit the immediate concerns of the person and/or his/her family and the reasons behavioral health services are being requested. The intent is to encourage persons to articulate, in their own words, what they hope to accomplish by their engagement with the behavioral health provider. The questions in this section serve to draw out information explaining why services are being requested at this time, the duration of the persons' concerns, the specific motivations that lead to the request for services and how these factors are affecting the person's life. Persons should be encouraged to discuss their desired outcomes and by what factors they would measure satisfaction with the services they receive. Persons'

preferences are also identified to further customize treatment to their unique cultures, faith, traditions and priorities. The information obtained in this section provides a context to develop both service and discharge plans. The information collected in this section may also provide answers to other questions asked later in the Core Assessment. In this case the assessor should avoid asking the same or similar questions multiple times, however, additional probing questions may be necessary.

Specific Questions

1. What are you seeking help for today?

Intent:
This question allows the person/family to identify why they are requesting behavioral health services at this time. Precipitating factors that resulted in their seeking assistance at this time should be identified. In many cases the person's/family's strengths/coping mechanisms/situational support have been effective for some time and these should be explored as a means of beginning the process of identifying strengths and internal resource.

Possible Probing Questions:
What is bothering you?
Tell me about why you are here today?
What prompted you to seek help? (explore whether the decision was voluntary)
Did something happen recently that told you now is the time to seek help?
What kept you from coming in sooner?

2. How long have these issues been a concern? How often are these an issue for you?

Intent:
To obtain information on the duration of the current distress as well as the frequency at which the person/family perceives their inability to manage their current situation. Change in situational support, perception of situation or increases in intensity are all important aspects to review.

Possible Probing Questions:
When did you first notice the problem?
How long have you been feeling this way?
Did it start manageable and worsen over time?
Have things been different or worse lately?

3. How do these concerns affect your daily living? How have they impacted your family/significant others?

Intent:
To examine the practical functional implications of the presenting issue(s). The impact on "activities of daily living" from the most basic self-care, hygiene and behavioral self-control to management of relationships, work situations, scheduling and mobility are important considerations to discuss here. A review of the person's perceived impact on his/her family and significant others as well as the family's view of the person's impact on their lives should also be

discussed.
It is particularly important to define these functional implications in determining SMI status of a person. For children, this area will be further explored as part of the strengths and cultural discovery process.

Possible Probing Questions:
Describe what is going right and what is going wrong.
How do the issues we talked about earlier get in the way?
When are these concerns problematic?
Do they keep you from things you want to or need to do?
Tell me about how this affects others?
Have others noticed or commented on these or similar concerns?

4. What has been done so far to address these concerns? What seems to help? What makes them worse?

Intent:
This question offers the assessor the opportunity to explore successful intervention strategies, internal strengths and family and community supports that have been successfully engaged in the past. It also allows inquiries into factors that are adversely impacting the person.

Possible Probing Questions:
Is there anything that makes these concerns/symptoms feel better?
What has helped in the past? What has not been so helpful?
Are there things that helped earlier, but do not anymore?
Is there anything that makes you feel worse?
What else have you done to try to help this?
What do you do to hold yourself together, get your work done, etc.?

5. How will you know if things are better/improving?

Intent:
Developing a successful service plan relies on an understanding from the onset of what the persons or family would like to achieve. The person is allowed to determine how he/she would measure success and what changes are personally most important and relevant.

Possible Probing Questions:
What would be different in your life, if you did not have these concerns?
How do you define better?
What will change when things are better? What will it look like? What will it feel like?
Who will notice you are feeling better?
Describe what you will be doing differently?

6. What type of resources or supports do you have available to help address these concerns?

Intent:
This question broadens the array of service opportunities to include the resources of friends, family and the community at large. It allows the person/family an opportunity to inventory all potential sources of support and assistance and begins to expand their concept of treatment. It encourages the development of a comprehensive, strengths-based, and community based service plan.

Possible Probing Questions:
Are there people in your life that you feel are supportive and might help you if they could?
Who can you talk to or go to for help/support?
What can you do to increase this support or help?

7. What type of assistance do you or others feel you need? (If others, specify who and relationship.)

Intent:
To identify the types of services or interventions that a person/family views as necessary, to assist in clarifying needs and service plan objectives. It is important to review perceptions or gain an understanding of what others have suggested would be helpful or necessary. This is particularly true for children, as school officials, state agency personnel or others close to the child may have valuable recommendations. It is also particularly useful in substance abuse situations where others may have shared concerns about the effects or impact of substance use on the person.

Possible Probing Questions:
Describe what would make things better? How can we help?
What kind of help do you want?
Have others suggested the type of help you need? If so, who and what?

8. Describe your preferences about behavioral health services relating to your culture, faith, spiritual beliefs or any other factors (e.g., provider gender preference, utilization of alternative medicine or traditional healer, sexual orientation)?

Intent:
The ethnic, racial, familial, regional, or spiritual culture in which individuals reside help define their sense of their world, and their way of thinking, feeling and responding. An effective portrait of a person and a successful service plan cannot be developed without exploring these factors. Barriers to effective communication, to treatment compliance and to feelings of engagement and respect can be addressed immediately, before they undermine service provision.
Attention should be paid to how the person/family interprets their own culture, religion, family practices and/or adherence to specific beliefs and/or traditions. This serves to assist in identifying additional external strengths that may be available and useful in the service planning process.

Possible Probing Questions:
Where did you grow up?
Who were the significant adults in your life?
What family traditions are important to you?

Do you have a spiritual or religious preference?
What kinds of people do you like / dislike?
Explore what factors influence the decision making of the person/family including their knowledge, attitudes and beliefs regarding health care/services?

Core Assessment: Behavioral Health and Medical History

At this point in the assessment interview, the assessor should review with the person/family their answers to the Behavioral Health and Medical History Questionnaire. If the person/family were not able to fill out the Questionnaire prior to the interview, the assessor should assist the person/family in completing the Questionnaire as part of the Core Assessment. For more information on the purpose of the Behavioral Health and Medical History Questionnaire and the specific questions it contains, refer to the previous section of this Guide on the Questionnaire.

Core Assessment: Criminal Justice

Purpose

The Criminal Justice section serves to identify those persons who are currently or have had previous involvement with the legal system (e.g., legal issues, probation, arrests, parole, court-ordered treatment). Identification of criminal justice involvement is important when assessing risk and identifying service needs including coordination with other agencies. In addition, often times the criminal justice system, probation, parole or other diversion services may provide important external strengths in the initial service planning process.

Specific Questions

1. Are you currently or have you in the past been involved with the legal system (e.g., probation, parole, jail, pending charges, court-ordered treatment)? □ No □ Yes, if yes, explain.

Intent:
To identify those persons who have been involved in some way with the legal system; obtaining a brief understanding as to what the involvement was.

If involvement with the criminal justice system is indicated, the more detailed set of questions contained in the **Criminal Justice Addendum** must eventually be completed for those persons. Completion of this addendum does not need to occur as part of the initial interview but can occur at a follow-up appointment.

Core Assessment: Substance Related Disorders

Purpose

The intent of the Substance Related Disorder section is to identify those persons who may be involved with alcohol or substances and for such persons to be able to establish a DSM diagnosis for abuse/dependence as well as elicit information for designing a mix of settings and services that will support long-term sobriety and recovery. The assessor should be aware that this section may need to be repeated or revisited as the person becomes more trusting and engaged in services.

This section addresses the following three areas:

- **Screening for Substance Use** (Questions A.1(a-d) and A.2 (a-c)): Identifies persons for whom substance use is a concern
- **Current and Past Substance Use** (Questions B.1 – 3): Collects specific details about current and past patterns of use, loss of control and other DSM criteria
- **Relapse and Recovery Environment** (Questions C.1(a-b) – C.2(a-b)): Assesses a person's current degree of relapse risk and identifies the level of support necessary for sustained recovery

Specific Questions

A. Screening for Substance Use

1. Based on a review of available documentation, the assessor should answer the following:

   a. Referral source indicates the person has a substance related problem? □ No □ Yes
   b. Person's medical history indicates past medical condition, hospitalization or emergency room treatment for a substance related medical issue (includes detoxification in the past 2 years)? □ No □ Yes
   c. Medication history suggests person is using prescription medicines in inappropriate combinations or doses? □ No □ Yes
   d. Person's behavioral health history indicates an episode of substance related treatment in the past 2 years? □ No □ Yes

2. If none of the answers above are yes then depending on the situation ask:

   a. Do you now or have you ever had a problem with alcohol or drugs? □ No □ Yes
   b. Is a spouse/significant other or family member concerned about your use of alcohol or drugs? □ No □ Yes
   c. If a parent/legal guardian/spouse/significant other is present ask:
      (i) Do you feel the person (and/or his/her friends in the case of a child) is currently using alcohol or drugs? □ No □ Yes
      (ii) Has the person (and/or his/her friends in the case of a child) gotten into trouble for such use? □ No □ Yes

Intent for Questions A.1 and A.2:
To identify persons for whom substance use is a concern as indicated by the person him/herself, a family member, a referral source or the person's medical or behavioral health history. These questions also serve as a trigger so that if the response to any of the questions A.1 or A.2 is yes, the assessor must complete the remaining questions in the Substance Related Disorder section.

The assessor should first complete the answers to questions A.1 (a-d), based on information obtained through the referral source, completion of the Behavioral Health and Medical Questionnaire or any other available information that the assessor has access to. If the answer is no to questions A.1 (a-d) then the assessor should then ask the person/family to respond to questions A.2 (a-c).

B. Current and Past Substance Use

Intent:
To capture specific details about a person's substance use within the past 12 months including current use (primary and secondary), route, dose and frequency information. This data, along with information about consequences and concurrent behavioral health conditions collected in other sections of the Assessment should be used by the assessor to develop a differential diagnosis for substance abuse/dependence as part of the clinical formulation. Information about historical use of substances beyond the 12 month timeframe, including substance problems currently in remission and family history of substance use/abuse should be documented in the record, although it is not the active focus of treatment.

1. What are your drinking habits? (e.g., How much, how often and what do you drink? Do you ever drink more than you meant to or feel preoccupied with wanting to drink? Have you neglected some of your usual responsibilities in order to drink? Have you felt you wanted or needed to cut down on drinking or tried to stop but could not? Have you given up or reduced important activities in order to drink?)

2. Have you ever taken any drugs other than alcohol to get high, sleep better, feel better or lose weight? (e.g., How much, how often, how used and reasons for use? Do you ever use more than you meant to or feel preoccupied with buying drugs or using drugs? Have you neglected some of your usual responsibilities in order to use? Have you felt you wanted or needed to cut down or tried to stop but could not? Have you given up or reduced important activities in order to buy or use drugs?)

Intent for Questions B.1 and B.2:
To gain a better understanding of the person's drinking/using patterns and ability to control his/her level, timing and duration of use based on DSM criteria within the past 12 months. These questions are also intended to assist in the identification of functional impairment in areas of life caused by drinking/using drugs such as neglecting responsibilities, giving up important activities, impacts on family life; attempts to control drinking, and preoccupation with obtaining alcohol/drugs and drinking or using.

Possible Probing Questions:
Do you ever drink/use more than you meant to or feel preoccupied with wanting to drink or use drugs?
Can you predict your behavior when you drink/use more than you intend? Does this happen frequently?
Have you missed or been late for work or school due to drinking/using? Have you spent money on alcohol or drugs instead of paying bills or buying food for your family?
Have you neglected your children or not taken care of them in the manner that you expect yourself to due to drinking/using? Have you had CPS involvement?
Has anyone objected to your drinking/using? Has a relationship ever ended due to your substance use?
Have you felt you wanted or needed to cut down on your drinking/using in the past year or tried to stop but could not?

3. Complete the table below for each substance the person has used in the past 12 months. However, in the far right column indicate primary (P) or secondary (S) for current substance use (i.e., used in past 30 day or 30 days before being placed in a controlled environment).

Intent:
To assess the person's current use and patterns of use in the past 12 months including:

- Increasing dose/frequency (tolerance) and risk of withdrawal.
- Current substances requiring treatment.
- Substance use in remission.
- Treatment matching

The information collected in the far right column of the table regarding primary and secondary current use is a data element that is reported to ADHS/DBHS and is used as an outcome measure.

An example of a completed table follows.

Example of Completed Table for Question B.3

Substance Use in Past 12 Months (please circle)	**Freq.** (use code below)	**Route** (use code below)	**Age First Used**	**When Last Used**	**Current Use (past 30 days) Primary (P) or Secondary (S)**
Alcohol	**4**	**1**	**10**	**Yesterday**	**S**
Marijuana	**5**	**2**	**11**	**Today**	**P**
Stimulants ▪ Methamphetamine ▪ Cocaine/crack ▪ Other (e.g., Ritalin, amphetamine)	**2**	**2**	**11**	**Two weeks ago**	
Opiates/Narcotics ▪ Heroin ▪ Other (e.g., codeine, hydrocodone, oxycodone, oxycotin, propoxyphene, non-prescription methadone)					
Depressants ▪ Benzodiazepines (e.g., Valium, Klonopin, Ativan, Xanax, Halcion) ▪ Other sedatives, tranquilizers hypnotics (e.g., Soma, Benadryl, barbiturates)	**3**	**1**	**25**	**Last Week**	
Hallucinogens: LSD, PCP, MDMA, sherms, ecstasy, ketamine, psilocybin, etc.					
Inhalants: glue, paint, gasoline, other solvents/aerosols, etc.					
Other Drugs: non-narcotic analgesics, GHB, other/unclassified and other medications used in excess of prescription [e.g., Prozac, Haldol, Robitussun]. Specify type:_____					

Codes for Table

Frequency of Use/Abuse:
- **1** No use in past 30 days
- **2** 1-3 times in past 30 days
- **3** 1-2 times per week
- **4** 3-6 times per week
- **5** Daily/multiple times per day

Route of Administration:
- **1** Oral
- **2** Smoked
- **3** Inhaled
- **4** Injected
- **5** Other (specify in table)

C. Relapse and Recovery Environment

1. Continued Use/Relapse Potential

1(a) Assess and describe the level of structure, supervision, safety and medication needed by the person in order to avoid/limit continued substance use or a relapse event (e.g., Will you drink/use when you leave here today? Have you ever abstained on your own before? When did that occur? How did you do that?)

Intent:
To determine the person's ability to abstain (i.e., relapse risk) and his/her current coping mechanisms.

Possible Probing Questions:
When was the longest period of time you have gone without using/drinking? When did that occur? How did you do that? What sources helped you?
What was going on in your life when you relapsed? Are there things in your life now that would make it hard to stop drinking/using?
What strengths do you think you have in your life that would support you in not drinking/using (e.g., hobbies, spiritual orientation, non-using friends/family)?

1(b) Based on this assessment, the assessor indicates below which statement best describes the person:

- ☐ Can Independently Abstain
- ☐ Need for Encouragement: Person needs encouragement not to use; has fair self-management and relapse coping skills.
- ☐ Need for Supervision: Impaired recognition or understanding of relapse issues, but able to self-manage with prompting.
- ☐ Need for Structure / Supervision: Little recognition or understanding of relapse issues; no/poor skills to cope with and interrupt addiction problems or to avoid/limit relapse; no imminent danger.
- ☐ Safety Risk: Person is unable to prevent relapse; continued use places person or others in imminent danger.

2. Recovery Environment

2(a) Assess and describe the level of support for recovery in the person's home, community and immediate surroundings, and the level of services and supports necessary for the person to cope with a negative environment (e.g., How does the person currently cope with his/her environment? Are these strategies effective? Is the person willing to learn more effective coping skills? Does the person need an alternative environment?)

Intent:
To determine the level of exposure to substance use or relapse triggers in the person's immediate environment, including family, housing and employment. The assessor is also examining the

person's ability to cope with environment without using or need for an alternative environment.

Possible Probing Questions:
Do the people around you (e.g., family, job, school, friends) support your sobriety? Do they use drugs or drink?
Are you able to walk away?
What supports would you need to remain abstinent in your current environment? (e.g., job, home, school)

2(b) Based on this assessment, the assessor indicates below which statement best describes the person:

- Environment is supportive of recovery.
- Environment contains triggers that exposes person to continued use (job, friends, school, neighborhood); able to cope most of the time.
- Person is living in an unsupportive environment; difficult/unable to cope even with clinical support.
- Person is living in an environment that would hinder recovery (shelter, non-therapeutic residential setting, homeless).
- Person is living with active users or in an abusive situation.

Core Assessment: Abuse/Sexual Risk Behavior

Purpose

The purpose of the Abuse/Sexual Risk Behavior section is to determine the safety of the person's home environment and the risk of physical, sexual or emotional abuse. The questions in this section were carefully crafted with the intent of exploring with sensitivity issues that are heavily emotionally laden and are likely embarrassing and difficult to discuss, particularly on an initial visit. The intent is not to explore the details of abuse, but to determine if abuse may be occurring.

The first four questions of this section inquire about feelings of safety, experiences that suggest abusive behavior by others and sexual behavior that may put the person at risk. These four questions are for all populations with sensitivity for the person's comfort level. The assessor is encouraged to ask them verbatim. If the responses to these core set of questions (or any other available information) suggest a risk of abuse, three more in-depth questions (i.e., Questions 5 – 7) are included that will provide the assessor with additional information leading to appropriate and required interventions. Questions 5 – 7 should not be asked if risk of abuse is not indicated.

Skilled assessors must carefully gauge these questions against a person's verbal and non-verbal responses and, when necessary, adapt their interviewing methods appropriately. Additional engagement may need to be done around these issues and consideration given to referring the person to a specialty provider. The assessors will also need to use their clinical judgment to assess whether these questions may need to be answered during subsequent appointments.

Specific Questions

1. Do you feel safe in your current living situation? outside of your home? □ Yes □ No, if no briefly explain.

> **Intent**:
> To assess the person's perception of safety in their current living environment. The response can provide an indication of abuse, nurturance, and support, and how the living environment is otherwise perceived. This allows the assessor to begin to determine the safety of the home.
>
> **Possible Probing Question**:
> What makes you feel that way?
> Are there any people in your house or neighborhood that make you feel threatened or scared?

2. Are you currently or have you ever been hurt, harmed, touched inappropriately, or abused by someone in any way? (Consider any physical, sexual, or emotional abuse) □ No □ Yes, if yes, explain including times when abuse occurred, action taken (e.g., notification of authorities, resulting steps taken).

> **Intent**:
> To identify safety in the home and/or a history of sexual or physical abuse. The answers can indicate a need for intervention, safety, or be a focus for treatment.

3. Is any member of your household/family <u>currently</u> being or has ever been harmed, abused, neglected, or victimized? (Consider any physical, sexual, or emotional abuse.) □ No □ Yes, if yes explain (including any Child Protective Services (CPS) or Adult Protective Services (APS) involvement).

> **Intent:**
> To identify the possible risks to the person; giving him/her a chance to indicate the need to intervene on behalf of a household member.
>
> **Possible Probing Question:**
> Are you worried about anyone else in your family being hurt? If so, who and how?

4. Do you engage in any sexual behaviors that you are concerned about, or that have raised concerns in your family or community (sexual acting out, inappropriate touching, exposure)? □ No □ Yes, if yes, explain.

> **Intent:**
> To identify at-risk behavior, and assess the person's awareness and perceptions of at-risk behavior.
>
> **Possible Probing Questions:**
> Do you and your parents ever argue about your sexual behavior?

Have you or your family ever had contact with protective service agencies such as APS, CPS or Tribal Social Services?

ONLY complete the remainder of the questions below, if the response is no to question 1 or yes to questions 2, 3 or 4.

5. How do you think the issues identified above affect you now?

Intent:
To assess insight, evidence of post-traumatic stress, interference in current functioning and effects on contemporary relationships. For example, has the person assumed responsibility for another's behavior?

Probes:
Do you have flashbacks to particularly scary moments or bad dreams about them?
Do you startle easily?
Do you get scared when you see someone who reminds you of people that have frightened or hurt you?

6. Do you believe that any of the issues that you have indicated above should be a focus of your treatment at this time? □ No □ Yes, if yes, explain.

Intent:
To help determine the person's readiness to explore these issues.

Possible Probing Question:
Would it be helpful to talk about this more in the future?

7. Based on the person's responses, does the assessor feel there is an immediate safety risk for the person or others in the household or members of the community? □ No □ Yes, if yes, explain.

Intent:
The assessor is required to appraise, from all available information shared, the level of risk to the person or to anyone else that may be imperiled by the person's living environment or behavior.

Duty to Report: If you as the assessor believe that the person is a victim of abuse, neglect or exploitation, you may have an obligation under A.R.S. 13-3620 or A.R.S. 46-454 to make a report to a peace officer or child/adult protective services. If duty to report is warranted explain the action to be taken.

Intent:
This paragraph is included to prompt the clinician about legal obligations. If there is any confusion about when and how to report, the assessor is encouraged to consult with his/her supervisor.

Core Assessment: Risk Assessment

Purpose

The purpose of the Risk Assessment section is to determine the person's over all ability to be safe in the community and to assess the need for immediate intervention (voluntary or involuntary), balancing all known factors. Factors will include risk/intent to harm, available supports, the existence of a safe and supportive environment, level of cognitive functioning, level of impairment from physical factors, and the presence of substance use.

Trigger questions in this section (Questions 1 and 2) are used to identify those persons who may be at risk for harm to self or harm to others. If risk of harm to self or others is suggested, the assessor should complete the remainder of the questions in this section (Questions 3 – 7) that will allow the assessor to more thoroughly explore risks and arrive at appropriate and required interventions. Questions 3 – 7 should not be asked if risk of self or harm to others is not suggested.

Specific Questions

1. Have you ever thought about harming yourself or someone else? □ No □ Yes, if yes, did you have a plan and when was the last time you thought about harming yourself?

Intent: To determine suicidal or homicidal ideation, self-injurious behavior, aggressive intent and possible hidden wishes or intent. **Possible Probing Questions:** Have you ever told anyone you wanted to hurt yourself or someone else? When things get really bad, have you thought about killing yourself? What keeps you from doing it? Do you have a plan? Have you ever wished you or someone else were dead?

2. Have you ever harmed/injured yourself or someone else intentionally? □No □Yes, if yes, did you have a plan and when was the last time you harmed yourself or someone else?

Possible Probing Questions: Have you ever tried to hurt yourself? What happened? Have you thought of hurting others? If so, who and how? Did anyone ever stop you from hurting yourself or others? What happened? Have you ever harmed an animal?

ONLY complete the rest of the risk assessment questions, if the response to question 1 or 2 is yes (note: complete questions 3 if the risk is harm to self and/or question 4 if the risk is harm to others).

3. Risk of Harm to Self

3(a) Indicate which of the following suicide risk factors apply to the person:

Prior suicide attempt	☐ No ☐ Yes	Behavioral cues (e.g., isolation, impulsivity, withdrawn, angry, agitated)	☐ No ☐ Yes
Repeated attempts; increasing severity	☐ No ☐Yes	Symptoms of psychosis (especially command hallucinations)	☐ No ☐ Yes
Stated plan with intent	☐ No ☐ Yes	Family history of suicide	☐ No ☐ Yes
Access to means (e.g., weapon)	☐ No ☐ Yes	History of suicide in friend	☐ No ☐ Yes
Substance use (current/past)	☐ No ☐ Yes	Terminal physical illness	☐ No ☐ Yes
Other self-abusing behavior	☐ No ☐ Yes	Current stressors	☐ No ☐ Yes
Recent losses / lack of support	☐ No ☐ Yes		

3(b) Provide more detailed explanation for any of the above risk factors that apply.

4. Risk of Harm to Others

4(a) Indicate which of the following homicide risk factors apply to the person:

Prior acts of violence	☐ No ☐ Yes	Access to means (e.g., weapon)	☐ No ☐ Yes
Fire setting	☐ No ☐ Yes	Substance use (current/past)	☐ No ☐ Yes
Angry mood / agitation	☐ No ☐ Yes	Symptoms of psychosis (especially command hallucinations)	☐ No ☐ Yes
Arrests for violence	☐ No ☐ Yes	Physically abused as child	☐ No ☐ Yes
Prior hospitalizations for dangerousness	☐ No ☐Yes	Current stressors	☐ No ☐ Yes

4(b) Provide more detailed explanation for any of the above risk factors that apply.

Intent for Questions 3 and 4:
The presence of positive responses to the above questions will inform the determination of relative danger to self or others and the need for immediate interventions. Although risk must be determined by a myriad of considerations, the greater the number of positive responses, the greater the risk.

Possible Probing Questions:
What is your plan for _____ (hurting yourself or others)?
What might you do to go about that?
Do you know anyone who has killed him/herself or someone else?
(For previous self-injurious behavior) Were there any signs that you were leading up to self harm?
Do you keep weapons around?
Have you been in many fights?
Have you been told that you have a temper?
Do you hear voices that tell you what to do?
Have you been physically abused?
Do you ever feel like you are going to explode?
Do you have a fascination with fires? Have you ever set a fire?
What current stressors are at the top of your list?

5. Does the person demonstrate symptoms that suggest a risk for DTs, withdrawal, seizures, overdose or toxic use that may require immediate interventions? □ No □ Yes, if yes explain.

Intent:
To assess behaviors, physical signs and symptoms that may require medical intervention. This includes making a determination of risk of withdrawal and should include the presence of physical symptoms such as sweating, shaking, pale pasty skin color, and lethargy. Consideration should also be given to the history of previous interventions needed by the person.

6. In terms of <u>other potential risk factors</u>, does the person appear:

Malnourished	☐ No	☐ Yes, if yes explain
Dehydrated	☐ No	☐ Yes, if yes explain
Dirty/malodorous	☐ No	☐ Yes, if yes explain
At-risk of exposure to the elements	☐ No	☐ Yes, if yes explain

Intent:
To assess other potential risk factors which assist the assessor in determining the person's over all ability to be safe in the community and the urgency of needed interventions (voluntary or involuntary) balancing all factors known. This is also important in assessing the person's ability to care for him/herself.

7. Considering the responses to the above risk factors in combination with all the other information you know about the person (e.g., gender, age, diagnosis, balancing factors – resiliency and supports), would you rate the level of risk for this person as:
□ Low Risk □ Medium Risk □ High Risk ? Please explain your rating.

Duty to Protect / Duty to Warn (Tarasoff and A.R.S. 36-517.02). This applies when a practitioner is confronted with a person who makes a credible threat against another identified individual. When this occurs, the practitioner must take reasonable steps to prevent harm per A.R.S. 36-517.02. If duty to protect/duty to warn warranted in this case, explain the action to be taken and factors affecting the decision.

Intent:
To determine if reasonable steps to prevent harm are required by ethics, liability, Tarasoff and ARS 36-517.02. If there is any confusion about when and how to report, the assessor is encouraged to consult with his/her supervisor.

Examples of items to consider when making this determination:
- Had the person made a threat against anybody?
- Is the individual identified?
- Is that threat credible?

Core Assessment: Mental Status Exam

Purpose

The overall purpose of the Mental Status Exam is to summarize the assessor's observations and impressions of the person at the time of the Core Assessment interview. It is the description of the person's speech, appearance, activities, thoughts and attitudes during the interview process. As opposed to the history of the person that remains constant, a person's mental status changes continually and must therefore be reassessed over time.

Some of the data of the mental status comes to light spontaneously, some only after careful and specific questioning. Thus, the data to be reported does not emerge in any special sequence or order. The categories outlined below are arranged for the assessor's convenience only. It is not necessary to elicit information in any specific order and it need not be covered in equal detail.

While lengthy clinical texts have been created dedicating chapters to each of the inquiries listed below the Mental Status Exam set forth in this section has been designed to provide several additional prompts for consideration by the assessor when completing this section of the assessment.

Traditionally, it is during the mental status evaluation that questions are asked to further elaborate on symptoms suggestive of common disorders, even if they are not formally reflective of mental functioning. Questions related to the vegetative signs of depression (e.g., sleep disturbance, changes in appetite, crying episodes), anxiety (e.g., fears, autonomic discharge, anticipatory apprehension), and psychosis (e.g., hallucinations, paranoia, ideas of reference) should be explored and documented.

Specific Questions

1. Describe the **person's interaction** with you and others in attendance; include general observations about the person's appearance, behavior and social interaction.

> **Intent:**
> The person's interaction is meant as a review of appearance (dress, hygiene and functional components related to self care) and social interactions. Behavioral presentation should be reviewed and related to cultural and/or ethnic norms as the person and his/her family perceives and practices them. For example, Did the person appear guarded, friendly, make good eye contact etc.? Did he/she volunteer information and initiate conversation? Was he/she poorly groomed, inappropriately dressed, etc?

2. **Motor Activity** (e.g., orderly, calm, agitated, restless, hypoactive, tics, mannerisms, tremors, convulsions, ataxia, akathisia).

> **Intent:**
> This category identifies quantitative and qualitative aspects of demeanor and motor behavior. In addition to the examples provided as part of the question, it might also include gestures, hyperactivity, rigidity, generalized slowing down of body motion, medication related movement

disorders, descriptions of gait, aimlessness, or other notable physical manifestations.

3. **Mood** (*Sustained emotional state,* e.g., relaxed, happy, anxious, angry, depressed, hopeless, hopeful, apathetic, euphoric, euthymic, elated, irritable, fearful, silly).

Intent:
This category describes the pervasive and persistent emotion that colors the person's sense of the world, particularly as it is described by the person him/herself. Descriptions should include depth, intensity, duration and fluctuations.

4. **Affect** (*Outward expression of person's current feeling state,* e.g., broad range, appropriate to thought content, inappropriate to thought content, labile, flat, blunted).

Intent:
This category defines the individual's present emotional responsiveness, in the moment, the current feeling tone observed during the assessment. Affect is what the assessor infers from the patient's facial expression, body language, tone of voice, and other observable behavior. As such, it may or may not be congruent with mood.

5. **Self-concept** (e.g., self-assured, realistic, low self-esteem, inflated self-esteem).

6. **Speech** (e.g., mute, talkative, articulate, normally responsive, rapid, slow, slurred, stuttering, loud, whispered, mumbled, spontaneous, stilted, aphasic, repetitive).

7. **Thought Process** (e.g., logical, relevant, coherent, goal directed, illogical, incoherent, circumstantial, rambling, pressured, flight of ideas, loose associations, tangential, grossly disorganized, blocking, neologisms, clanging, confused, perplexed, confabulating).

Intent:
This category describes the way a person puts together ideas or associations, the form in which a person thinks. It refers to both the organization and flow of thought. Assessment of thought organization may suggest irrelevant thoughts, the lack of ability to engage in goal-directed thinking, unclear cause and effect relations (are thoughts unrelated or idiosyncratically related?), poorly connected shifts in topics (loose associations), tangential thinking (losing the thread of the conversation and veering from one topic to another), or disturbances of continuity (e.g. rambling, evasive, preservative). Thoughts may be blocked before an idea has been completed. Flow may take the form of slowness of thought, hesitation, or a pressure of thought and speech. Rapid thinking, carried to an extreme, may be considered flight of ideas.

8. **Thought Content** (e.g., optimistic, grandiose, hopeless, delusions, preoccupations, hallucinations, ideas of references, obsessions/compulsions, phobias, poverty of content, suicidal or homicidal ideation, prejudices/biases, hypochondriacal, depressive).

Intent:
Content refers to what a person is actually thinking about: ideas, beliefs, preoccupations, obsessions, delusions, phobias, fantasies, etc. Suicidal or homicidal ideation should be included.

9. **Intellectual Functions:**

9(a) **Sensorium** (e.g., orientation – person, place, time, situation).

9(b) **Memory** (e.g., recent, remote, retention and recall (3 object memory, recall: immediate / 5 minutes; digit span memory).

9(c) **Intellectual Capacity** (e.g., general information (current events, geographical facts, current/past presidents), calculations (serial 3's or 7's), abstraction and comprehension (comparison and differences, proverb interpretations)).

9(d) **Estimated Intelligence** (e.g., below average, average, above average, unable to determine).

10. **Judgment and Impulse Control** (e.g., good, partial, limited, poor, none).

11. **Insight** (e.g., good, fair, poor, none).

Core Assessment: Clinical Formulation and Diagnoses

Purpose

The Clinical Formulation and Diagnoses section functions as the bridge between the Core Assessment and the Service Plan. The purpose of this section is to summarize the information gathered in the Core Assessment, to make one or more provisional DSM diagnoses and to summarize other diagnostic factors such as the medical condition of the person. The section is divided into two parts:

- Clinical Formulation/Case Summary
- Diagnostic Summary

Specific Questions

A. Clinical Formulation/Case Summary: The assessor should ensure this succinct paragraph:

- Provides a descriptive picture of the person through summarization of pertinent data for person's medical/ behavioral health history and mental status findings.
- Summarizes how bio-psycho-social, environmental, cultural, personality and family factors and unique mental/social functioning have influenced person's history and current status.
- Identifies strengths and needs of person and his/her family.
- Prioritizes needs to be addressed; allowing assessor and person/family to readily understand what needs to be done next.

Intent:
The purpose of this summary paragraph is to provide a comprehensive picture of the person that illuminates the evolution of his/her unique strengths and concerns. As part of this paragraph, the assessor should:

- Identify, summarize and prioritize the needs to be addressed (safety, security, symptoms, rehabilitations and support);
- Identify the strengths and resources identified during the assessment process that can promote successful service provision;
- Present an approach / beginning service plan to assist both the assessor and the person/family in prioritizing and meeting their presenting concerns; and
- Indicate the type and urgency of the next appointment.

B. Diagnostic Summary:

1. **Axis I**

DSM-IV TR Code	DSM-IV Diagnosis	DSM-IV TR Code	DSM-IV Diagnosis
DSM-IV TR Code	DSM-IV Diagnosis	DSM-IV TR Code	DSM-IV Diagnosis
DSM-IV TR Code	DSM-IV Diagnosis		

2. **Axis II**

DSM-IV TR Code	DSM-IV Diagnosis	DSM-IV TR Code	DSM-IV Diagnosis

Intent:
To provide a DSM diagnoses for the person based on the information obtained through the Core Assessment.

If there is not enough information to make a differential diagnosis, the assessor is encouraged to use V codes that generally define relational problems, problems relating to abuse or neglect, or other conditions that may be a focus of clinical attention. This way the assessor can avoid attempting to prematurely assign a diagnosis until sufficient information is obtained. In using the V codes, it is important for the assessor to remember that:

- A V code cannot be used for a Level I admission.
- If 799.9 (Diagnosis or Condition Deferred) is used, it must be replaced with a specific DSM IV diagnosis within 45 days of the initial intake appointment.

In addition for use in service planning, the DSM IV code is also needed for billing purposes and is reported to ADHS/DBHS as part of the demographic data submittal.

3. **Axis III - Medical Conditions:** Identify the person's specific medical conditions and check the disease categories below that apply.

A. ☐ **Infectious and Parasitic Diseases** (001-139): abscesses, infections, tuberculosis, HIV/AIDS, pneumonia, blood infections
B. ☐ **Neoplasms** (140-239): cancer
C. ☐ **Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders** (240-279): diabetes, thyroid or hormonal disorders, iron or vitamin deficiencies, salt imbalances, immune deficiencies
D. ☐ **Diseases of the Blood and Blood-Forming Organs** (280-289): hemophilia, anemia
E. ☐ **Diseases of the Nervous System and Sense Organs** (320-389): blindness, deafness, loss of sensation, Parkinson's disease, multiple sclerosis, Lou Gehrig's disease (ALS), Huntington's disease (chorea), Alzheimer's disease, strokes with loss of function
F. ☐ **Diseases of the Circulatory System** (390-459): heart attacks, strokes, heart failure, aneurysm, loss of circulation in extremities
G. ☐ **Diseases of the Respiratory System** (460-519): asthma, chronic obstructive lung disease, emphysema
H. ☐ **Diseases of the Digestive System** (520-579): stomach disorders, ulcers, esophageal reflux (GERD), Crohn's disease, colitis, constipation, hemorrhoids, liver disease, pancreatic disease
I. ☐ **Diseases of the Genitourinary System** (580-629): urinary incontinence, bladder problems, menstrual disorders, ovarian, cervical or uterine disorders, prostrate disorders, kidney (renal) disorders
J. ☐ **Complications of Pregnancy, Childbirth, and the Puerperium** (630-676): peri-natal disorders
K. ☐ **Diseases of the Skin and Subcutaneous Tissue** (680-709)
L. ☐ **Diseases of the Musculoskeletal System and Connective Tissue** (710-739): orthopedic disorders, fractures/dislocations/deformities
M. ☐ **Congenital Anomalies** (740-759): genetic disorders, birth deformities
N. ☐ **Certain Conditions Originating in the Perinatal Period** (760-779): failure to thrive, cholic, feeding problems
O. ☐ **Symptoms, Signs, and Ill-Defined Conditions** (780-799)
P. ☐ **Injury and Poisoning** (800-999): traumatic injuries, ingestions of poisonous/toxic substances

Intent:
To summarize the person's specific physical health conditions, based on information the assessor obtained through the Behavioral Health and Medical History Questionnaire. This information should be used to determine if a referral to a PCP is needed. In addition, this information is reported to ADHS/DBHS as part of the demographic data submittal.

4. **Axis IV - Psychosocial or Environmental Stressors**

Problems with / related to:

☐ Primary Support Group	☐ Educational Problems	☐ Occupational Problems
☐ Marital Problems	☐ Housing Problems	☐ Interaction with Legal System
☐ Access to Health Care Services	☐ Family Problems	☐ Substance Use in Home

☐Other_____

Significant recent losses:

☐ Death	☐ Injury	☐ Medical/Surgical
☐ Job	☐ Divorce/Separation	☐ Accident/Injury
☐ Child removed from home	☐ Violent Acts Against Person/Family	

☐Other_____

5. **Axis V - Global Assessment of Functioning (CGAS/GAF) Score** (specific score not a range):

Intent:
The Global Assessment of Functioning reflects the assessor's judgment of the person's overall level of functioning. This information will be useful in service planning, predicting prognoses, and is reported to ADHS/DBHS as it serves as a primary source for measuring outcomes. In

addition if an adult has a GAF score of 50 or lower and an SMI qualifying diagnoses, the assessor must determine SMI status by completing the SMI addendum.

Scale	Children's Global Assessment Scale (CGAS) Children (16 years of age or younger)	Global Assessment of Functioning (GAF) (All Others)
100-91	Superior Functioning	Superior Functioning
90-81	Good Functioning in All Areas	No or Minimal Symptoms
80-71	No More Than Slight Impairment in Functioning	Slight Impairment if Symptoms are Present
70-61	Some Difficulty in A Single Area, But Generally Functioning Pretty Well	Mild Symptoms
60-51	Variable Functioning with Sporadic Difficulties or Symptoms in Several but Not All Social Areas	Moderate Symptoms
50-41	Moderate Degree of Interference in Functioning in Most Social Areas or Severe Impairment of Functioning in One Area	Impaired Reality Testing/Major Symptoms in Several Areas
40-31	Major Impairment in Functioning in Several Areas and Unable to Function in One of These Areas	Some Impaired Reality Testing / Major Impairment in Several Areas
30-21	Unable to Function in Almost All Areas	Delusional / Hallucinations / Inability to Function in Almost All Areas
20-11	Needs Considerable Supervision	Danger to Self/Others/Gross Impairment in Functioning/Hygiene
10-1	Needs Constant Supervision	Persistent Danger/Serious Impairments

If the person has a GAF score that is 50 or lower and also has an SMI qualifying diagnosis, the assessor must complete the SMI Determination Addendum.

Core Assessment: Next Steps/Interim Service Plan

Purpose

The purpose of the Core Assessment until this point has been to identify the immediate needs and strengths of the person/family, to provide a foundation for ongoing assessment, and to produce enough information to decide what, when and how initial care should be delivered. The Next Steps/Interim Service Plan section serves as a way of organizing and documenting these tasks and triaging the person/family to the most appropriate next service. By completing this section, the assessor will design the service array that will be put into place until a full assessment is completed. Individuals who can serve as resources to the person/family and who may serve on the team will be identified, the need for additional information will be established and a contact person within the provider system will be determined. The person's or guardian's signature reflects their endorsement and participation in the development of the recommended next steps.

For urgent responses to children removed from their home by the Department of Economic Security, Child Protective Services (CPS), additional considerations come into play in response to the unique service needs of children removed from their homes by CPS. This includes the traumatic impact of the removal process, the potential return of the child to his/her family, the needs of the child's new caregivers as they accommodate to the situation, and the needs of the child to maintain contact with those individuals important to his/her life.

Specific Questions

1. Identify specific people who may be supportive and helpful and who should be invited to be part of the person's ongoing Team, including phone numbers and action to be taken.

2. Identify any additional documentation (e.g., medical records, IEP, probation report) which needs to be collected to assist in the ongoing assessment and service planning including the individuals and/or agencies and action to be taken to obtain this information.

3. Identify who the person and/or family/legal guardian/significant other should contact if the person needs immediate assistance before the next appointment.

4. **Interim Service Plan.** Based on the person's presenting issues, your impressions and the preferences of the person and his/her family/legal guardian/significant other, describe in the Interim Service Plan on the next page recommended next steps (e.g., formation of Team, response to immediate risks and needs of the person, further assessment). Additionally, this Interim Service Plan should include:

    - Any immediate next steps to be taken by the person and/or family/legal guardian/significant others.
    - Referral to the person's primary care physician, if *physical health problems* have been identified.
    - Additional considerations for urgent response for children removed by Child Protective Services (see shaded box below).

Assessors may add a goal statement, if appropriate.

For urgent response for children removed by **Child Protective Services, the assessor must include as part of the recommended next steps/interim service plan, identification of:

1. Actions needed to be taken immediately to mitigate the effects of the removal itself;
2. Supports and services the child's caregivers may need to meet the child's needs;
3. A plan to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral health needs within at least the next 23 days (or sooner as indicated).

The assessor may also provide any input he/she has regarding the types and amount/frequency of contact (e.g. visits, phone calls, email etc.) the child should have with parents, siblings, relatives, and other individuals important to the child.

Intent:

To develop an interim service plan that clearly describes the next steps that will take place in order to, provide a foundation for ongoing assessment and address the person/family's immediate needs by triaging the person/family to the most appropriate next service. Depending on the individual circumstances and needs of the person/family, the plan should if appropriate include:

- Include steps to address any concerns about the person's immediate safety and security.
- Medical referrals for persons such as those who are pregnant, have an Axis III diagnosis, need a physical examination.
- Psychiatric referrals for persons such as those taking psychiatric medication, exhibiting symptoms of mania, vegetative or physical symptoms of depression, a thought disorder, psychosis.
- Specific recommendations related for children removed by CPS (e.g., actions to mitigate effects of removal, caregiver supports, plan for reassessing child).

An example of a completed interim service plan follows.

Example of Completed Interim Service

Description of Next Steps (Action) to Be Taken	**Who Will Be Responsible to Ensure Action Occurs**	**Where Action/Step Will Take Place (e.g., provider)**	**When Action/ Step Will Take Place**
1. Contact PCP and arrange for an appointment for medical concerns identified during the assessment.	Ann Smith, Clinical Liaison and Joan	Appointment will occur at PCP Office on Osborn Street.	Apt will be scheduled today and held within 7 days.
2. Joan will discuss potential participation in service planning with her husband and mother and call Ann to notify her when this has been done.	Joan will invite family and notify Ann Smith.	Joan will make the invitation after dinner this evening.	This evening.
3. Ann will arrange the next appointment including family members and will also schedule a psychiatric appointment for the same day.	Ann Smith	The next appointment will occur at the 24th Street Clinic.	Within 23 days.
4. Joan will attend PCP appointment and will bring the results to the psychiatric appointment.	Joan	PCP Office and 24th Street Clinic.	Within 23 days.
5. Joan will begin to keep a record of her eating and sleeping patterns and other symptoms of depression using the Hamilton Depression Inventory. Joan will also keep a list of activities that she enjoyed doing between her clinic visits.	Joan	At her home and at work.	Begin today and report at next meeting.

_____ _____

Person/Guardian Signature Date

_____ _____ _____

Assessor's Name (print) / Signature Credentials/Position Date

_____ _____ _____

Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

_____

Agency

Note: The assessor should make sure to provide the person/guardian with a copy of the interim service plan. The CPS specialist, however, should receive a copy of the entire next steps/interim service plan section.

ADDENDA

Addenda which may be completed by the assessor at a follow-up meeting(s) examine additional life domains of the person in order to build a more complete picture of the person and his/her family, identify the impact of the presenting concerns on functional life areas and further identify strengths and additional supports.

There are 9 additional Addenda some of which must be completed on all persons being assessed and others that are targeted at certain populations and or triggered by responses to questions in the Core Assessment. The Addenda include:

- Living Environment (for all persons)
- Family/Community Involvement (for all persons)
- Educational/Vocational Training (for all persons)
- Employment (for persons 16 years and older and others if pertinent)
- Problem Gambling Screen (for persons 16 years and older)
- Developmental History (for all children or for adults who have developmental disabilities)
- Criminal Justice (for persons with legal involvement, triggered by response to question on legal involvement in Core Assessment)
- Seriously Mentally Ill Determination (for person who request SMI determination or who have a qualifying SMI diagnosis and a GAF score that is 50 or lower)
- Child Protective Services (used for 24 hour urgent response for children removed by Child Protective Services)
- Special Suicide Risk Assessment (for all persons in crisis situations)

Prior to completing the Addenda the assessor should review the information that has already been obtained through the Core Assessment as well as the background information collected during the intake. This information (e.g., primary residence, employment status, concerns about daily living) can be used to focus the questions and possible probes as well as avoid redundant questioning.

For each of the Addendum, a brief statement regarding the purpose of the specific addendum is provided below in addition to the intent and possible probing questions for specific questions contained within these addenda.

Addendum: Living Environment

Purpose

The purpose of the Living Environment Addendum is to gain an understanding about the support system the person has developed, his/her day-to-day stressors, and how he/she copes with activities of daily living. A person's environment (e.g., where and with whom one lives) influences his/her ability to implement his/her service plan and who might be available to help them in his/her recovery. If needed, assisting the person with securing a safe and appropriate living environment should be a priority for service planning.

Specific Questions

1. Briefly describe your living environment. Where do you live? Do you like it? Who do you live with? How do you spend a typical day? (e.g., What is the flow of your day like? Do you have specific daily activities - what are they, which ones do you enjoy? Do you know each day what you will be doing that day? Do you do things at the same time each day? Are you with others during the day? What makes for a good day?)

Possible Probing Questions:
What do you like best about where you live? What do you like least?
For group settings:
- Do you feel respected by the people you live with?
- Do you have privacy where you live?

2. Have you recently experienced any <u>significant</u> change in your living environment/situation (e.g., removal from family, divorce, adoption, school suspension, family death, auto accident, loss of job/income)? □No □ Yes If yes, how have you dealt with this issue?

Intent:
Given that change can cause stress for a person even if it is change for the better, the intent of this section is to identify possible stress related changes (especially loss related changes) that affect a person's ability to cope with his/her life situation.

Possible Probing Questions:
How have these changes affected you?
How did you deal with this issue?
What do you see happening next?

3. If appropriate ask: How long have you been in this country? How is life different here?

Intent:
Persons who have only recently immigrated to the United States may not have an understanding of how to access generic resources and may need assistance in understanding potential social service that may be available to them. Persons may also lack the extended family contacts that were previously available and may need assistance in developing relationships with religious or social organizations.

If indicated by results of Mental Status Exam and/or responses to Risk Assessment questions in the Core Assessment ask:

4. How well are you able to complete activities of daily living (e.g., bathing, eating, dressing, household management, homework, chores)? Explain any difficulties, including the type of assistance required.

Intent:
To understand issues a person may be facing in performing activities of daily living. Answers to this question may point directly to needs, possible services for the person and/or need for further assessment. This question is related to Question 3 in the Presenting Problems section of the Core Assessment and is very critical in the determination of SMI status. The response to this question can also be used to further identify self-care needs of the person or the person's ability to care for others that will need to be addressed through living skill training, other supports or other generic resources.

Possible Probing Questions:
How have you managed living on you own?
How long have you had these difficulties?
What/Who has helped you to live on your own?
Do you/your child need assistance with _____?

Addendum: Family/Community Involvement

Purpose

The Family/Community Involvement Addendum is intended to assist the assessor in getting to know the person outside of the symptoms and the diagnostic checklists. The Addendum asks questions about who the person is - in his/her relationships and in his/her culture and about trust and perceptions of self. An important focus is the identification of a person's strengths, which then need to be built upon and included in the service plan as well as emphasized to facilitate hope for recovery and change. The assessor's openness to hearing the person's story and willingness to ask how a person wants to be treated shows respect and begins engagement in the therapeutic process.

In addition to this Addendum, a Strengths and Cultural Discovery document which builds off of the information gathered during the assessment process will eventually need to be completed on all children enrolled in the ADHS/DBHS system. Information on how to complete the Strengths Cultural Discovery is included in other training currently being provided in each T/RBHA.

Specific Questions

1. Describe the relationships you are involved in and how you feel about these people (e.g. family, friends, significant others, staff person if in out-of-home placement, community relationships). In general, how do you get along with others?

Intent:
To gain a sense of the person's connectedness, ability to form and keep relationships, support system and possible resources by asking about the people in the person's life.

Possible Probing Questions:
Who do you hang out with most often?
What kinds of things do you do with other people?
Who is in your family?

How often are you able to get together with any of them?
Who do you believe likes you a lot and is supportive of you?
Who are some "close friends?"
How long have most of your friendships lasted?

2. Which people are you most comfortable confiding in? Do you think these people would be supportive and helpful to you at this time? □ No □ Yes, who are these people and how do they help? (contact information is optional)

3. What are the things that make you feel good about yourself and help make your life meaningful (including interests, strengths, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, your culture/community, work, school, etc.)?

Intent:
To identify what makes this person unique including what the motivators are, things he/she likes to do, things he/she are good at doing. It also looks to values and non-tangible underpinnings of behavior that can be used to shore up the person in difficult times. Strengths discovery is at the core of the service plan development. This question is an opportunity to get the person thinking about both internal and external supports and resources as a complement to their presenting issues.

Possible Probing Questions:
What do you do for fun?
Do you have hobbies or an avocation?
Describe your best qualities and talents?
What kinds of things give you a lift? Calm you down?
Where do you get your strength to get through each day?
What things can you count on your family for?
Do you have family traditions around holidays or birthdays?

4. What do others consider to be your strengths (including interests, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, your culture/community, work, school, etc.)?

Intent:
To understand not only how the person sees him/herself, but also how the person sees him/herself in relation to others. Sometimes it is easier to talk about oneself through the eyes of others.

Possible Probing Questions:
What do your kids see as good things about you?
How do you think your boss rates your work? What do you do best?
What do your friends like about you?
How would one of your friends describe you to me?
How would your friends, family members or co-workers describe you?

5. Is there anything about you, your family or your culture that would help us understand you, and how people respond to you? How does your culture influence you or people around you? Please describe.

Intent:
The intent of this question is to have the person describe in their own words how they see and experience the world and solve problems.

Possible Probing Questions:
What do you think has been the biggest influence on how you turned out?
What might be some things that make you or your family unique?
Is there anything I need to know about your culture, your beliefs, and your values in order to make it easier for us to work together?
Is there someone else in your family who should be consulted and involved in the work with your son?
Who do you look up to? Who has influenced your life?
Have you had/or do you have a mentor?

Addendum: Educational/Vocational Training

Purpose

The intent of the Educational/Vocational Training Addendum is to assess other areas in the person's life where there may be either success or difficulty. The area of education or vocational training often reveals strengths, skills and interests as well as long-range goals. The responses to the questions in this section can tell the assessor what a person does all day but also introduce possible collaborators, supports and resources.

Specific Questions

1. Are you currently involved in an educational or vocational training program? □ Yes □ No

1(a) If yes, describe how you are doing in school/training: (Do you like it? What about it do you like? Do you participate in any activities?)

Intent:
To identify interests, skills or strengths of the person as well as to identify any evidence of problem solving strategies, coping, ability to complete a program or recognition of one's own strengths.

For children, in particular, educational status is reported to ADHS/DBHS and is used as an outcome measure.

Possible Probing Questions:

What do you like about it? What don't you like about it?
What is your favorite subject?
What activities do you participate in?
What are you good at?
What is difficult?
How do you get through the hard stuff?

In addition the assessor should look at the background information collected at intake which should indicate if the person is currently in school or vocational programs.

1(b) If no, are you interested in becoming involved in an educational or vocational training program? □ No □ Yes, if yes please explain your reasons and describe your interests.

Intent:
To understand motivation, goals, and areas of interest, stressors, and possible need for additional supports for education or vocational activities.

Possible Probing Questions:
What kinds of things do you see yourself studying and later doing for work?
Have you been in educational / vocational programs before?
What helps you perform well?

1(c) If no and of school age, what situations have lead to you not being in school?

Intent:
To understand the person's needs and wants, this information may be used later to help develop service plan goals.

Possible Probing Questions:
How long have you been out of school?
What happened?
What could have helped you to complete your education?
What do you need now to make it work?
(Ask some of the suggested probes for Question 1(a) above as it relates to when they were in school.)

2. Describe how school/training impacts or has impacted your life (both positive and negative aspects).

Intent:
To identify insight, future orientation, goal setting and perseverance. The assessor should listen for anger, frustration, and discouragement in the response.

Possible Probing Questions:
Overall has education / training been a good thing or a bad thing for you?

How does it fit in with your future plans?

3. What is or has been your prior experience in school/training?

Possible Probing Questions:
What did you like or dislike about school?
Tell me something from your favorite class that you learned?
What happened?

4. Have you ever been told you have special educational needs? □ No □ Yes, what was done about it (testing, special evaluation, special classes, development of an IEP/504, alternative school, change of teacher)?

Intent:
To identify needs, possible collaborators and special services already in place.

Possible Probing Questions:
Are you / have you ever been in any special classes?
Do you remember any special tests you took with the school psychologist by yourself?
What kinds of subjects did you get help with?

Addendum: Employment

Purpose

The Employment Addendum provides the assessor with an understanding of the person's ability to hold a job, attitude about working and the overall impact that employment (including military history) has on one's life. From this discussion important strengths may be identified which can later be used in augmenting skills and personal resources in supporting recovery. Conversely, difficulties getting, keeping or tolerating employment or the ability to function in some settings and not others may be identified. All of this information helps identify skills/resources that help the person maintain employment and roadblocks/issues that prevent the person from performing in the work place. This information should be used in diagnosis and service planning. In addition, employment status is reported to ADHS/DBHS and is used as an outcome measure.

The Employment Addendum should only be completed on persons who are 16 years of age or older or if pertinent for persons who are younger. The assessor should look at the background information collected at intake which should indicate if the person is currently in school or vocational programs.

Specific Questions

1. Are you currently working (full, part-time or volunteer)? □ Yes □ No

1(a) If yes, describe your current job, (e.g., type of work, work environment, length of employment, attitude toward work) and how the work affects your life (e.g., family, leisure time, health, relationships)?

1(b) If no, when was the last time you worked (i.e., date) and what prompted the change (e.g., reasons you left that job)? Are you interested in finding employment (describe interests)?

Intent:
To identify the strengths of the person and to understand why the person is not working and/or if they are interested in working in the future.

Possible Probing Questions:
What type of job do you think you would like to do?
Have you ever been trained to do a certain job? If so, are you still interested in that kind of work?

2. Describe your work and/or military history. How do you feel about it? How has it has impacted your life?

Intent:
To determine what work or military experience the person has had and whether it was/is a positive or negative experience.

Possible Probing Questions:
How old were you when you first worked? When you went into the military?
Do you have a resume that describes your work history?
What was your favorite job?
What did you do in the military? What did you enjoy most about this experience?

3. Describe strengths or barriers that have influenced your ability to work.

Intent:
To identify the person's strengths/weaknesses at work including areas the persons may require assistance.

Possible Probing Questions:
Tell me about what helps you at work? What makes work harder?
What do you think your boss would say he/she likes about the way you do your job?
What do you think your boss would say you could do better at your job?
Have your symptoms or the issues we talked about earlier ever caused you any problems in doing your job?

4. Are there any supports or resources you need in order to get a job and/or keep your current job?

Intent:
To identify what the person needs to get or keep a job.

Possible Probing Questions:
How do you get to work?
Do you ever need help getting to work?
Does your job require special equipment or a uniform?
Do you ever need help in talking to your supervisor/co-workers?
Have you ever had a job coach?

Addendum: Problem Gambling Screen

Purpose

The purpose of the Program Gambling Screening Addendum is to collect information about 1) the person's current and past patterns related to gambling and betting and 2) assess the impact that gambling or betting behaviors have on the person's current situation/lifestyle. The Problem Gambling Screening Addendum should only be completed on persons who are 16 years of age or older.

A "yes" response to either Question 1 or 2 is an indication that the person may need treatment for a gambling problem (see DSM IV 312.31). For Title XIX/XXI eligible persons, this issue should be taken into consideration in the development of the person's service plan. If the person is not eligible for Title XIX/XXI services, the assessor should refer the person to the Arizona Office of Problem Gambling that operates a state-funded gambling treatment program or if available, to a problem gambling program provided by the assessor's agency. The Arizona Office of Problem Gambling can be reached via their Toll Free Helpline 1-877-921-4004 or at 602-266-8299. Additional information about this Office and the issue of problem gambling is available on their website www.problemgambling.az.gov.

Specific Questions

1. Have you ever felt the need to bet more and more money?

Intent:
To gain an understanding of the person's gambling patterns and ability to control his/her gambling.

Possible Probing Questions:
Describe your gambling habit.
Where do you typically gamble/bet (casinos, internet, etc)?
Have you ever bet more than you planed, budgeted or anticipated to do?
Have you had repeated unsuccessful efforts to control, cut back or stop gambling?

Have you ever borrowed money to finance your gambling?
Have you gambled to get money with which to pay debts or to solve other financial problems?
Do you ever gamble to escape?

2. Have you ever had to lie to people important to you about how much you gambled?

Intent:
To assist in the identification of functional impairments/impact on person's/family's life caused by problem gambling such as neglecting responsibilities, giving up important activities, attempts to control gambling, and preoccupation with gambling.

Possible Probing Questions:
Have you ever neglected some of your usual responsibilities so you could gamble?
Have you given up or reduced important activities so you could gamble?
Do you ever feel preoccupied with wanting to gamble?
Have you ever jeopardized or lost a significant relationship, job or educational or career opportunity because of gambling?
Has gambling ever made you careless of the welfare of yourself or your family?

Addendum: Developmental History

Purpose

The Developmental History Addendum allows the assessor to understand and document key elements of the person's social, emotional and physical skill development. This developmental assessment is important in:

- Identifying possible developmental problems and the need for further diagnostic evaluation.
- Providing an objective description of a person's abilities and deficits.
- Determining the need for other programs (e.g., developmental disability services).
- Assisting in planning for appropriate interventions.

The Developmental History Addendum should be completed on all children and for adults who have developmental disabilities. For persons who are served by the DES-DDD ALTCS program, the DDD staff will bring this information to the initial intake appointment.

Specific Questions

1. During pregnancy did this person's mother:

Receive health care?	☐ No ☐ Yes, if yes specify:
Drink alcohol?	☐ No ☐ Yes, if yes specify:
Use tobacco?	☐ No ☐ Yes, if yes specify:
Use any illicit drugs?	☐ No ☐ Yes, if yes specify:

Use any medications?	☐ No ☐ Yes, if yes specify:
Have any medical or emotional problems?	☐ No ☐ Yes, if yes specify:
Experience complications during labor/delivery?	☐ No ☐ Yes, if yes specify:
Give birth premature?	☐ No ☐ Yes, if yes specify:

Intent:
To understand the heath status of the person's mother during her pregnancy.

2. Timing of Developmental Events

(a) By 0-1 year of age, had this person:

Sat up?	☐ Yes ☐ No, if no explain
Crawled?	☐ Yes ☐ No, if no explain

- By 1-3 years of age, had this person:

Walked alone?	☐ Yes ☐ No, if no explain
Used first words?	☐ Yes ☐ No, if no explain
Fed self with spoon?	☐ Yes ☐ No, if no explain

(c) By 3-5 years of age, had this person:

Been toilet trained?	☐ Yes ☐ No, if no explain
Used first sentences?	☐ Yes ☐ No, if no explain
Learned to ride a tricycle?	☐ Yes ☐ No, if no explain

3. Other Developmental Issues: Indicate below if the person ever experienced any of the following:

(a) Could not gain weight	☐ No ☐ Yes, age began _____ and if resolved when
(b) Wet the bed or soiled his/her clothes	☐ No ☐ Yes, age began _____ and if resolved when
(c) Had difficulty with coordination	☐ No ☐ Yes, age began _____ and if resolved when
(d) Had difficulty with speech	☐ No ☐ Yes, age began _____ and if resolved when
(e) Had unusual sensitivity to touch	☐ No ☐ Yes, age began _____ and if resolved when
(f) Had difficulty with social skills	☐ No ☐ Yes, age began _____ and if resolved when
(g) Was evaluated for taking too much time to develop certain skills (e.g., communicating, reading, spelling) ☐ No ☐ Yes, if yes specify:	
(h) Was evaluated for speech and language delays?	☐ No ☐ Yes, if yes specify:

4. Please provide any additional information that might be helpful regarding any other issues or significant events that should be considered.

5. Has or is the person receiving services from the Department of Economic Security, Division of Developmental Disabilities (DDD)? ☐ No ☐ Yes, describe. (Also make sure to indicate, if available, the worker's name and contact information on the cover sheet.)

Addendum: Criminal Justice

Purpose

The Criminal Justice Addendum is designed to collect more in-depth information about the criminal justice history and/or current trouble with the law for those persons identified in the Core

Assessment as having involvement with the legal system. This information can be a starting place for assessment of the person's judgment, motivation for change, employability, affiliations, commitment to family/community and level of risk. It is also important to explore the situation and factors that may have contributed to the person's actions (e.g., substance use, peer pressure, economic factors). The person's probation or parole office may become a valuable ally or support in treatment and the change process.

Specific Questions

1. Recent Criminal Justice History

1(a) **Criminal Justice Involvement**	**Current (last 30 days)**	**Past Six Months**
Legal Issues (e.g., pending charges, court dates)	☐ No ☐ Yes	☐ No ☐ Yes
Probation	☐ No ☐ Yes	☐ No ☐ Yes
Parole	☐ No ☐ Yes	☐ No ☐ Yes
Court-Ordered Treatment	☐ No ☐ Yes	☐ No ☐ Yes
Arrests		☐ No ☐ Yes, if yes how many?

1(b) Provide additional information about any of the items marked "yes" above.

Intent: To complete a more in depth exploration of the person's recent (past 30 days and past 6 months) criminal justice involvement. The number of arrest within the past 6 months is also reported to ADHS/DBHS and is used as an outcome measure.

Possible Probing Questions:
If pending charges, what are the charges and when is your next court date?
What type of treatment did the court order?
Why were you arrested?
Were others (friends or family members) with you at the time of your arrest?

2. Does this person have a Probation/Parole Officer? ☐ No ☐ Yes, indicate type and conditions of parole/probation.

Intent:
To determine if the person has a Probation/Parole Officer and if there are any legal limitation or treatment requirements that the person may have as part of their parole/probation. As part of the service planning process it will be important to include the Probation/Parole Officer on the person's Team and to ensure that care is appropriately coordinated between the two systems.

Possible Probing Questions:

Are there any requirements of your parole/probation that can have an effect on your treatment?
Does your parole/probation have treatment requirements?

If "yes" make sure the Officer's name and phone number is recorded on the Cover Sheet.

3. Describe any other significant offenses** for which you have been arrested/charged and/or adjudicated (including type of offense, date of offense, legal action taken, resolution, current status) and what impact these events have had on your life.

Intent:
To identify significant criminal or legal issues that occurred previous to the 6 month interval reported above and to gain an understanding as to how these events have impacted the person's life.

**Offenses might include but not be limited to any of the following: alcohol/tobacco, arson, assault/battery, auto theft, burglary, child molestation, criminal damage, cruelty to animals, curfew violation, domestic violence, drugs (possession, distribution), endangerment/weapons, DUI/DWI, forgery, fraud, manslaughter/murder, probation/parole violation, prostitution, robbery, sexual assault/rape, shoplifting, theft, trespassing, truancy.

4. As a result of involvement with the legal system, have there been any positive aspects/benefits that have resulted for you and/or your family? If so, please describe.

Intent:
To determine if the person has had any positive interactions with the criminal justice system.

Possible Probing Questions::
What were some of your positive experiences?
Were there any interactions with any aspects of the criminal justice system (i.e. judge, defense attorney, victims advocate, community service etc) that were not negative?

Addendum: Seriously Mentally Ill Determination

Purpose

The objective of the Serious Mentally Ill Determination Addendum is to ensure the prompt and accurate identification of persons with a serious mental illness (SMI). This Addendum should be used for all persons who are referred for, request, or have been determined to need an eligibility determination for SMI (i.e., person has qualifying SMI diagnosis and a GAF score that is 50 or lower). See PM Section 3.10, SMI Eligibility Determination, for the process for completion of SMI eligibility determination.

Specific Questions

I. Preliminary SMI Determination Recommendation

Based upon my direct behavioral health assessment of this person, I _____ _____
Assessor's Name (print) Credentials/Position & Signature

Make the following preliminary SMI eligibility recommendation.

1. Preliminary Recommendation of Qualifying SMI Diagnosis *(Circle the person's principal diagnosis (es) supported by available information)*

Psychotic disorders (295.10, 295.20, 295.30, 295.60, 295.70, 297.1, 295.90, 298.9); **Bipolar disorders** (296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89); **Obsessive-compulsive disorder** (300.3); **Major Depression** (296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36); **Other Mood Disorders** (296.90, 301.13, 311, 300.4)**; Anxiety disorders** (300.00, 300.01, 300.02, 300.14, 300.21, 300.22, 309.81); **Personality disorders** (301.0, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, 301.9)

Intent:
To determine if the person has a qualifying SMI diagnosis. Not all DSM diagnoses are qualifying SMI diagnoses.

When completing, reference the following section of the Core Assessment:
- Clinical Formulation and Diagnoses **(**Diagnostic Summary - Axis I)

1(a) The above noted diagnosis(es) is/are suggested based upon the following signs and symptoms of the mental disorder(s): (Provide descriptions of both positive (confirming) findings and negative ("rule-out") findings for other diagnoses that were considered.)

When completing, reference the following sections of the Core Assessment:
- Mental Status Exam
- Clinical Formulation and Diagnoses (Clinical Formulation/Case Summary, Diagnostic Summary - Axis IV and Axis V)

1(b) Based on the assessment and other available information, the person's current GAF score was determined to be _____.

When completing, reference the following section of the Core Assessment:
- Clinical Formulation and Diagnoses (Diagnostic Summary - Axis V)

2. Preliminary Recommendation of Functional Criteria As a result of the above diagnosis, the person exhibits any item listed under 2 (a), (b) and/or (c) for most of the past twelve months **or** for most of the past six months with an expected continued duration of at least six months:

☐ 2(a) **Inability to live in an independent or family setting with out supervision (Self Care/Basic Needs)** - The person's capacity to live independently or in a family setting, including the capacity to provide or arrange for needs such as food, clothing, shelter and medical care.

- ☐ Neglect or disruption of ability to attend to basic needs.
- ☐ Needs assistance in caring for self.
- ☐ Unable to care for self in safe or sanitary manner.
- ☐ Housing, food and clothing, must be provided or arranged for by others.

- ☐ Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care.
- ☐ Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions.
- ☐ Refuses treatment for life threatening illnesses because of behavioral health disorder.

When completing, reference the following sections of the Core Assessment:
- Presenting Concerns
- Behavioral Health and Medical History Questionnaire
- Clinical Formulation and Diagnoses (Clinical Formulation/Case Summary, Diagnostic Summary - Axis IV and Axis V)

☐ 2(b) **A risk of serious harm to self or others (Social/Legal and/or Feeling/Affect/Mood)** - The extent and ease with which the person is able to maintain conduct within the limits prescribed by law, rules and social expectations, and/or the extent to which the person's emotional life is well modulated or out of control.

- ☐ Seriously disruptive to family and/or community.
- ☐ Pervasively or imminently dangerous to others' bodily safety.
- ☐ Regularly engages in assaultive behavior.
- ☐ Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior.
- ☐ Persistently neglectful or abusive towards others in the person's care.
- ☐ Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan.
- ☐ Affective disruption causes significant damage to the person's education, livelihood, career, or personal relationships.

When completing, reference the following sections of the Core Assessment:
- Mental Status Exam
- Risk Assessment
- Clinical Formulation and Diagnoses (Clinical Formulation/Case Summary)

☐ 2(c) **Dysfunction in Role Performance** - Person's capacity to perform the present major role function in society --- school, work, parenting or other developmentally appropriate responsibility.

- ☐ Frequently disruptive or in trouble at work or at school.
- ☐ Frequently terminated from work or suspended/expelled from school.
- ☐ Major disruption of role functioning.
- ☐ Requires structured or supervised work or school setting.
- ☐ Performance significantly below expectation for cognitive/developmental level.
- ☐ Unable to work, attend school, or meet other developmentally appropriate responsibilities.

When completing, reference the following sections of the Core Assessment:
- Presenting Concerns
- Substance Related Disorders
- Clinical Formulation and Diagnoses (Clinical Formulation/Case Summary)

Also reference the following Addendums, if completed:
- Living Environment
- Employment

- Educational/Vocational Training

3. Risk of Deterioration

☐ The person does not currently meet any one of the above functional criteria 2(a) through 2(c) but may be expected to deteriorate to such a level without treatment.

- ☐ A qualifying diagnosis with probable chronic, relapsing and remitting course.
- ☐ Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.).
- ☐ Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.).
- ☐ **Other** (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

Intent:
To determine if the person who meets the diagnostic criteria would be able to maintain at his/her current level of functioning without treatment.

When completing, reference the following sections of the Core Assessment:
- Substance Related Disorders
- Clinical Formulation and Diagnoses (Clinical Formulation/Case Summary, Diagnostic Summary - Axis III, Axis IV and Axis V)

Also reference the following Addendums, if completed:
- Living Environment
- Employment
- Educational/Vocational Training

If the assessor concurs with the statement, document reason.

4. The above noted Functional Criteria ratings are suggested based upon the following information regarding this person's functioning: (Provide a description of both the positive (confirming) findings and negative ("rule-out") findings of the functioning of this person)

Assessor's Name (print) / Signature	Credentials/Position	Date

II. Final SMI Eligibility Determination

- ☐ **SMI** - All of the available information supports the conclusion that the above person has a qualifying diagnosis (1) AND either meets one or more functional criteria (2) OR is at risk of deterioration (3) and therefore meets ADHS/DBHS clinical criteria for SMI.
- ☐ **Not SMI** - The above person does not meet ADHS/DBHS clinical criteria for SMI.

Clinical rationale for final determination:

Reviewer Name (print) / Signature	Credentials/Position	Date

Addendum: Child Protective Services

Purpose

The Child Protective Services Addendum was developed for the purpose of ensuring that the urgent responses to children removed from their homes by Department of Economic Security, Child Protective Services (CPS) adequately determines the status of the child in the midst of a crisis, assesses and supports the child in a manner that mitigates the trauma of the removal itself, determines the most appropriate immediate interventions, and ensures that appropriate information is obtained to help inform the CPS case manager, and the Court at the child's Preliminary Protective Hearing.

Recognizing that an accurate portrait of the child's overall strengths and needs will likely be overshadowed by the immediate crisis at hand, the priority at this initial interview is to address the child's immediate needs. This can be accomplished by completing this Addendum, Behavioral Health Client Cover Sheet and Client Demographic Information Sheet and the following sections in the Core Assessment: Risk Assessment, Mental Status Exam, Diagnostic Summary and the Next Steps/Interim Service Plan. The remainder of the Core Assessment should be completed at this time only if the child's clinical condition and circumstances allow. Otherwise, these sections can be deferred and completed later. In all situations, a preliminary diagnosis must be given. As there may be inadequate information to formulate a comprehensive diagnosis at this point, V codes should be considered.

The Addendum includes a brief checklist of a child's likely immediate response to the removal process itself, correlated to age. The assessor's observations and impressions of these responses, in conjunction with other data obtained through this Addendum and in conjunction with those gathered from Risk Assessment, Mental Status Exam, Clinical Formulation and Diagnosis, should serve as the basis for completing the Next Steps/Interim Service Plan.

The questions contained in this Addendum are primarily intended to be responded to by the Child Protective Services specialist involved with the child's case. In addition the assessor should make sure that the Child Protective Services specialist's name and phone number is recorded on the Cover Sheet that is placed in the child's behavioral health record. The Child Protective Services Specialist must receive a copy of the Addendum, Behavioral Health Client Cover Sheet and Client Demographic Information and any sections of the Core Assessment that are completed, e.g., Risk Assessment, Mental Status Exam, Diagnostic Summary and the Next Steps/Interim Service Plan.

Specific Questions

1. What are the reasons for the removal of the child from the parent /guardian? Are there other siblings in the family and/or living in the same home? Are other siblings victims of abuse and has CPS removed them? Explain

Intent:
Consideration must be given, not only to the child being removed, but also to the safety of others in the home. Feelings about a sibling's danger, status and advantages serve as significant clinical underpinnings to a child's response to removal.

2. Has the child had prior involvement with Child Protective Services? □ No □ Yes, if yes explain.

Intent:
To complete a more in-depth exploration of the child's and family's involvement with CPS and to gather previous history of abuse.

3. What is the child's perception of his/her parents, siblings, and/or family? What is the child's perception of his/her relationship with his/her parents/siblings/family? What are the child's feelings, sense of attachment, trust, security, love and affection toward his/her parents/guardian?

Intent:
Regardless of the child's experience in the home, the quality of the relationship between child and parents must be assessed and carefully considered when determining how best to reduce the trauma of the removal. Protecting the child while maintaining the nurturing and support a child receives from a parent can lead to the most appropriate intervention.

4. Was the child or the family receiving behavioral health services prior to the removal from the parent/guardian's home? □ No □ Yes, if yes explain.

Intent:
To identify previous behavioral health treatment received by the child or family. This may have been in other states or with other T/RBHAs.

For Questions 5 through 9 the assessor should check below those statements which best describe the child based on the assessor's observations and discussion with the Child Protective Service specialist at the time of the interview.

Intent for Questions 5 through 9:
These observations and impressions augment the Mental Status Evaluation, help determine the quality of the child's response to the removal, and inform the clinical team about immediate interventions.

5. General presentation for children 0-3 years of age
   - ☐ Crying
   - ☐ Clingy
   - ☐ Hard to soothe
   - ☐ Regressed
   - ☐ Tantruming
   - ☐ Disengaged
   - ☐ Head-banging

6. General presentation for children 4 years of age or older:
   - ☐ Listless, withdrawn
   - ☐ Disinterested

- ☐ Anxious
- ☐ Fearful
- ☐ Angry
- ☐ Labile
- ☐ Fussy
- ☐ Shocked
- ☐ Sad
- ☐ Hearing voices
- ☐ Suicidal
- ☐ Violent, homicidal

7. Understanding of removal process:
   - ☐ Confused
   - ☐ Self Blaming
   - ☐ Realistic
   - ☐ Distorted
   - ☐ Age appropriate
   - ☐ No understanding
   - ☐ No age appropriate understanding

8. Sense of future
   - ☐ Hopeful
   - ☐ Realistic
   - ☐ Unrealistically Optimistic
   - ☐ Pessimistic
   - ☐ Empowered
   - ☐ Planning own destiny
   - ☐ Unable to perceive a future
   - ☐ No age appropriate understanding

9. Understanding of placement options
   - ☐ Good
   - ☐ Poor
   - ☐ No age appropriate understanding

Intent for Question 7:
Children may be confused about the removal process, unaware of the reasons they are being separated from their families and placed with strangers, concerned that they will never see their parents and siblings again, unaware of what a foster home is, etc. Children may assume they are somehow to blame. Assessing their comprehension of the experience they are undergoing will lead to the most appropriate immediate intervention, which may be reassurance, education, or therapeutic intervention.

10. Describe the child's way of coping with the removal (e.g., blaming others, in denial, developing physical symptoms, regressing in behavior, accepting, etc.).

11. What do you or the child feel will be helpful in soothing the child, providing immediate comfort or mitigating the trauma of the removal? (e.g., special foods, transitional object, parental visits, maintenance in current school, contact with friends, church attendance.)

12. Describe any requirements of the child welfare plan that may affect the child's behavioral health service plan (e.g., limited parental or sibling involvement.)

Intent:
To determine if there are any legal limitations to treatment for the child; such as court orders preventing contact between parent and child or limited supervised contact.
As part of the service planning process, it will be important to include the CPS case manager on the child's Team and to ensure that care is appropriately coordinated between the two systems. The child's CPS case manager is a valuable and critical support in treatment planning and through the course of the child's stay in foster care.

Possible Probing Questions:
Ask the CPS case manager: Are there any legal requirements that can have an effect on or need to be considered for the child's treatment?
Do you (CPS case manager) have any child welfare plan requirements that need to be considered in treatment planning?

13. Assessor should provide summary of observations.

Intent:
To provide a brief case summary of the information that the assessor has been able to obtain from this initial interview.

Addendum: Special Suicide Risk Assessment

Purpose
The Special Suicide Risk Assessment Addendum was developed for the purpose of ensuring that persons in crisis situations receive a comprehensive assessment of suicidal risk. Any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk. The assessment is designed to determine the status of the person in crisis by evaluating them on multiple levels (current presentation of suicidality, psychiatric illnesses, history, psychosocial situation, and individual strengths and vulnerabilities) and assessing the level of lethality and potential self-harm when suicidal ideation is present. Recognizing that an accurate portrait of the person's overall strengths and needs will likely be overshadowed by the crisis at hand, the priority at this initial interview is to address the person's immediate needs. The goal is ultimately to secure the safety of the person by determining the most appropriate interventions.

The Addendum is designed for use in a variety of settings, including but not limited to: clinics, residential treatment facilities, crisis and first responder teams, etc. It can also be used for incoming crisis calls via telephone, although that was not the primary intent. In certain situations, phone staff may initially start the assessment, but the crisis mobile response team who responds to the call will later complete the form. Please note instructions for Question 2 below.

Specific Questions
1. Presenting Problem or Request for Assistance

Intent:
This may be explicitly stated (i.e. asking the person the reason for the call or visit), or the

assessor's clinical observation.

2. Triage
    a. Are you able to keep yourself safe until this assessment is completed?
    b. Are you in possession of a gun or weapon?
    c. Do you have easy access to a gun or weapon?
    d. Have you felt like hurting yourself or anyone else?
    e. Have you already hurt yourself or anyone else?

Intent:
The person's immediate safety is the primary concern. These questions are designed to rapidly assess the immediate risk of harm towards self or others. For example, if the situation is a crisis call via telephone, this triage is intended to quickly determine the need to dispatch a mobile response team. If the person answers "yes" to Question 2e above and the team has been dispatched to continue the assessment at the scene, it is not necessary to complete the remainder of this form. However, phone staff should attempt to keep the person on the phone until the team has arrived. If the person answers "yes" to Question 2d above for "hurting anyone else," refer back to the Core Risk Assessment for Harm to Others.

3. Ideations

Intent:
Using the person's own words, describe any thoughts of dying, hurting, or killing oneself in detail, as expressed in response to Question 2c above. The assessor should inquire about what circumstances trigger suicidal thoughts, paying particular attention to possible symptoms of PTSD, physical or sexual abuse, substance abuse, mood and personality disorders. Using the scale to the right, rate the lethality (no thoughts-obsessive thoughts). *Example: If ideation is non-existent, check "None." If thoughts are fleeting, check "Low." If periodic, check "Med." If constant, check "High." If ideation has been increasing in severity, urgency, or frequency, to the point where that is all the person can think about, check "Severe."*

Possible Probing Questions:
How often do suicidal thoughts occur? When did this begin? Did any event (stressor) precipitate the suicidal thoughts? Do these thoughts happen at a certain time of day? What do you feel while you are experiencing these thoughts?

4. Plan

Intent:
How would the person carry out his/her ideations? If the person has identified a plan, what are the specific methods considered? Using the scale at right, rate the lethality by the level of specificity of the plan. *Example: No plan=None; Plan is unclear or not fully developed=Low to Med; Plan is detailed and specific=High; Specific time, place, method=Severe.*

Possible Probing Questions:
Do you have a plan to end your life? Have you chosen a specific time or place? (If yes,) What is the significance of that date/time/location?

5. Means

Intent:
Using the person's own words, explain the instruments to be used. This can also be a follow up to Questions 2b and 2c above. Inquire about access to means. Culture and gender play an important role. Some methods may be more prevalent among a particular culture or population. It is crucial that assessors approach this portion of the interview with care and sensitivity. Avoid bringing your own belief system into the situation. Take caution to prevent instilling any feelings of guilt. Try to identify what the meaning of this act would be to this individual. Using the scale at right, rate the lethality by level of access to means. *Example: If person has mentioned using a gun but does not own one or have access to one, the assessor might select "None." If person does not own one but knows where to get one, or has easy access, this could fall between "Low" and "High" based on the assessor's clinical judgment. If the gun is in the bedside drawer, it would be "Severe."*

Possible Probing Questions:
Do you own a gun? Do you have access to any other potentially lethal weapon? Harmful medications? Illicit drugs?

6. Lethality

Intent:
Explore the dangerousness of the plan, using the person's own words. As stated above, culture and gender play an important role. Males typically choose more lethal methods. Using the scale at right, rate the lethality by level of certainty of death. *Example: firearms are typically the most lethal method and would rate "Severe," whereas jumping from a one-story building would pose minimal risk and therefore rate "None" on the scale.*

Possible Probing Questions:
Is the gun loaded? How much medication would you take?

7. Intent

Intent:
Reports the desire and intent to act on suicidal thoughts. Use the person's own words. Rate the lethality using the scale at right by their level of desire to complete the plan. *Example: If person has no desire to follow through, check "None" but be sure to provide details in the narrative box. Suicide is an act of desperation and often impulsive, so although the person might not have the desire or energy to complete the plan at the present time, this could easily change. If the person has made specific arrangements (i.e. note, suicide pact, will, etc.), check "Severe."*

Possible Probing Questions:
How far did you get with your plan? What has prevented you from acting on these suicidal thoughts? Have you considered the outcome of your suicide? What would it be like if you were dead? Have you made any specific arrangements? Have you given away any of your possessions?

8. History

Intent:
Previous attempts and knowing someone who has completed suicide are two of the most strongly correlated risk factors for suicide. Begin with the past three months. Using the person's own words, rate the lethality based on the number and/or severity of attempts using the scale at right. *Use your best clinical judgment in selecting the appropriate rating. Consider the lethality, even if the number of attempts is low. Also consider how the loss has impacted the person if they know someone who has completed suicide. The more recent, lethal, and frequent the attempt(s), the higher the person would rate on the scale.*

Possible Probing Questions:

Do you know anyone who has attempted or completed suicide? Friends? Family members? Have you ever tried to hurt yourself? Have you ever attempted suicide before? How many times? How long ago? What method did you use? How did you survive?

9. Substance Use/Abuse

Intent:
Another prevalent risk factor that is strongly correlated with suicide is substance abuse. Substance use lowers inhibitions and leads to emotional instability and impulsivity. Explore the person's current and historical use of substances, inquiring about access. Begin with the past three months. If currently using, describe the substance, amount, and when it was last taken. Note also any history of family member substance abuse. Using the scale at right, rate the lethality based on the level of use, from no use to dependence. *As a general rule, the more recent and frequent the use, the higher the rating.*

Possible Probing Questions:
Do you currently use any substances (smoke, drink, use drugs)? If so, how much? How often? When did you have your last cigarette/drink/etc.? When do you feel most like drinking/smoking/using drugs? Have you ever felt that your drinking/drug use is interfering with the quality of your life? Does anyone in your family have or has ever had a problem with drinking/drug use?

10. Acute Life Stressors

Intent:
Recent changes with family, relationship, job, school, health, marital status, or residential instability can lead to depression. Inquire about personal or financial losses, employment status, and living situation. Especially when working with youth, pay particular attention to symptoms of bullying, physical or sexual abuse or neglect, and quality of interpersonal relationships. Using the scale at right, rate the lethality by number of stressors. *Use your best clinical judgment. For example, the number of stressors may be low, but they might weigh more heavily on the person and justify a higher rating on the lethality scale.*

Possible Probing Questions:
Have you experienced any recent losses? Has anything changed with your living situation,

family environment, employment, finances or relationship in the last few months? (For youth) Tell me about school…what are your friends like? Do you like school? Was there a particular event recently that triggered any suicidal thoughts?

11. Depression/Agitation

Intent:
The assessor should note the person's affect, observing any signs of restlessness, anxiety, or depression. Inquire about sleep patterns, changes in diet or nutrition, and participation in daily activities. Try to get an idea of what "normal" means to this individual by using the scale referred to below. *Generally speaking, the more frequent and severe the depression, the higher the ranking on the scale at right.*

Possible Probing Questions:
Have you noticed any changes in sleeping habits recently? How about your eating habits? Describe what a typical day is like. How do you feel today (scale of 1-10)? On a good day, how would you rate yourself? How about when you are at your worst?

12. Hopelessness

Intent:
Determine the person's ability to see the future. Using the scale at right, rate the lethality by level of hopelessness.

Possible Probing Questions:
Are there any major events happening in the next several months? What are you most looking forward to?

13. Psychotic Processes

Intent:
Explore any history or current signs of psychosis, including delusions, auditory or visual hallucinations, etc. Include dates, diagnoses and treatments, including hospitalizations and medications. Pay particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders (including PTSD), and personality disorders (especially borderline and antisocial personality disorder). *Use your best clinical judgment and observation in determining the rating at right. In general, the more prevalent the symptoms, history, or frequency, the higher the severity.*

Possible Probing Questions:
Has there ever been a time in your life when you have sought help for any sort of mental problem? Have you ever been treated or hospitalized for mental illness? (How long ago?) Are you currently on any medication for mental illness? (What type, how much, how often?) Do you have any family members that have experienced any type of mental illness?

14. Medical Factors

Intent:
Inquire about current or past medical conditions, including chronic and severe pain, terminal illness, etc. Include previous diagnoses and treatments, including surgeries or hospitalizations, as well as medications. Recent changes in medical condition are an important factor to consider, especially with older adult persons. *In general, the more symptoms or severe the condition, the higher the ranking.*

Possible Probing Questions:
How would you rate your health at the present time? Have you experienced any recent changes in your medical condition? Do you have any chronic pain? Are you taking any medication? Have you ever been hospitalized?

15. Behavioral Cues

Intent:
Explore the person's level of control over his/her suicidal thoughts. Impulsivity is a risk factor, especially for adolescents. The assessor should pay attention to any signs of hostility, rage, etc. This section is based primarily on clinical observation. *In general, the more extreme the behavior or the less control the person has over it, the higher the risk.*

Possible Probing Questions:
Do you feel you are in control of your life? How do you feel when you aren't in control? Do you ever want to hurt someone or yourself? Do you trust yourself when you are alone?

16. Coping Skills

Intent:
Having a lack of adequate coping skills is a risk factor. Explore the person's past responses to stress as well as his/her ability to tolerate psychological pain and satisfy psychological needs. Pay attention to any mention for use of substances as a coping mechanism. Using the scale at right, rate the lethality by quality of coping skills. *In this category, the less coping skills or the poorest choices of coping skills would rank the most severe.*

Possible Probing Questions:
How do you typically deal with a stressful or unpleasant situation? What makes you feel better? What makes you feel worse? Do you ever use alcohol or drugs to dull the pain?

17. Support System

Intent:
Supportive relationships are a protective factor against suicide. Ask the person to describe the quality of their interpersonal relationships with family, friends, co-workers, roommates, etc. What is the person's role in the community? Include any mention of spiritual affiliations, civic roles, etc. The goal is to explore this person's reasons for living as well as to assess the level of supportive relationships in this person's life. *In this category, the less support the person has, the more severe the lethality.*

Possible Probing Questions:

Who do you feel is most supportive in your life? (For youth) At school? What is your relationship like with your family? What stops you from killing yourself?

18. Other Factors

Intent:
This section is primarily intended for the assessor's notes and observation. If the person has previously mentioned any of the following, explain here: recent lifestyle changes, sexual identity/orientation issues, involvement with justice system, etc. Sexual identity issues are a considerable risk factor, especially for youth. Using the scale at right, rate the lethality by the significance of these additional risk factors. *The more significant the impact, the higher the severity.*

Possible Probing Questions:

Is there anything else that has been going on recently? How has that affected your outlook on life?

19. Cultural Considerations

Intent:
This section is primarily intended for the assessor's notes and observation, not direct questioning. If the person has previously discussed their culture in terms of how it has shaped their personal growth or affected their decision-making, note here. Culture includes gender, race, ethnicity, religious or spiritual affiliation, etc. Studies have proven that culture, religiosity, and spirituality are protective factors against suicide. Take care to approach this area with sensitivity. Have their cultural views on death and suicide influenced their acceptance, ambivalence, or rejection of suicide? Note any mention of how their culture views behavioral health issues in general, realizing that stigma prevents many persons from seeking help for behavioral health disorders.

Possible Probing Questions:
Are you a spiritual or religious person? How do your culture or spiritual beliefs play a role in your desire to seek help? Do you feel accepted?

20. Overall Risk Level

Intent:
In this section, the assessor should evaluate all above information to determine the person's overall risk towards completion. Consider the person's energy toward follow through, their current level of distress, the specificity and lethality of their plan including access to means. Also consider their history of previous attempts, current stressors, and any depression and/or substance abuse. *The assessor should use their best clinical judgment. In general, the more "High" and "Severe" boxes checked, the higher the overall risk level. However, the factors mentioned above are more strongly associated with risk of suicide and should be weighed more heavily. The next section provides an area to summarize these risk and protective factors and the opportunity to explain your ranking.*

21. Reasoning

Intent:
Summarize risk factors and factors offsetting those risks. As stated above, list those risks that are most concerning and those factors that are most protective and offset those risks.

22. Action Taken

Intent:
Note actions taken, including details of appointments and referrals made, whether the person has a Crisis Plan, Interim Service Plan, etc. Identify any follow up required. The person's safety is the immediate concern.

BEHAVIORAL HEALTH SERVICE PLAN

In tandem with the assessment process, service planning should be an ongoing process resulting in an individual service plan for the persons that is a living clinical document continually being changed to meet the needs of the person and his/her family. It is important to view the Behavioral Health Service Plan as the person (and family)'s service plan not the provider agency or clinician's plan. To that end the Service Plan should be written so the person and his/her family can readily understand the service/treatment objectives and when they have met the objectives as well as their responsibility to follow through with their plan. The Service Plan must be directly linked to the results of the Case Formulation section of the Core Assessment that was previously discussed.

While ongoing, the service planning process is also short term with the life of any single Service Plan being brief in its orientation. Although technically a Service Plan in Arizona is good for a maximum of one year, Clinical Liaisons are encouraged to set objectives that can be readily accomplished and celebrated within a much shorter timeframe. The goal is to stop reinforcing failure but encourage involvement, achievement and success, continually building on the strengths of the person and his/her family. The initial Service Plan must be completed within 90 days of the person's initial appointment.

There are two parts to the overall Behavioral Health Service Plan, the actual Service Plan and the Review of Progress that is used to document the ongoing assessment process and evaluation of progress toward meeting service planning goals. Below are specific instructions for completing the Service Plan and the Review of Progress.

Service Plan: Completion Instructions

The instructions for the Service Plan follow the Service Plan form (see Appendix D which contains an example of a completed Service Plan) starting at the top and moving left to right across the document. Enter the Name, CIS Client ID#, Program, Today's Date (the date on which the Service Plan is being completed), and the names and titles of the Individuals at the Service Planning Meeting.

Recovery Goal/Person-Family Vision: This section should describe a sense of where the person wants to be or end up and how they will know when a service is no longer needed. The goal should provide a vision of how the person would like their life, family and environment to be. While the goal does not initially have to be a realistic goal, the Clinical Liaison should assist the person in identifying what will be needed for them to move toward their vision. It is important to remember and to remind the person that the Recovery Goal and Vision is a living box that will continue to be modified and changed frequently.

Person's Strengths: The Clinical Liaison should summarize person/family strengths that have been identified through the assessment process with the expectation that one will continue to add to this area as other strengths are identified in the future. Strengths may include internal strengths of the person, application of his/her strengths by the person and/or support people available to the person in times of distress. It is these strengths that need to be drawn upon in developing the interventions to meet the person's specific service plan objectives.

Review Date: The review date should reflect the date when the person's service plan will next be reviewed by the person (and family), Clinical Liaison and other appropriate Team members. The review date should coincide with the date by which the person is expected to have met the specific objectives listed on the plan.

Identified Needs and Specific Objectives: When identifying the needs and developing the specific objectives to address these needs, the Clinical Liaison should refer to the Clinical Formulation/Case Summary and Diagnoses section of the Core Assessment. It is essential that the Clinical Liaison use their skills in helping the person/family and team members understand that needs must be prioritized so that specific emergent or health needs or safety factors (e.g., abuse, risk, living arrangements, and medications) are addressed first.

The objectives should be brief, clear statements that are measurable and make practical, common sense to the person/family who "owns" the service plan. Given the dynamic changes that may need to be made in the plan and the fact that the Clinical Liaison needs to build a momentum of success, it is recommended that the Service Plan contain no more than 3 to 5 objectives at one time.

Measure (Current, Desired and Achieved): A quantifiable means to measure each service plan objective needs to be established. The goal is to coordinate care in an understandable and achievable way. On the Service Plan, the Clinical Liaison should indicate the current measure (where the person currently is in terms of meeting his/her need and desired outcome) and in collaboration with the person/family establish what the desired measure should be (e.g., the measure used to determine that the service objective has been met) and the target date for achieving these objectives. During later reviews of the Service Plan, the Clinical Liaison will record on the plan what measure that person has achieved at the time of the review.

Interventions to Meet Objectives: In this section of the Service Plan the Clinical Liaison should describe how each of the service objectives is going to be met. While this should include identification of covered behavioral health services, including type and frequency, it is also important to identify those other generic or community services that might be drawn upon to help meet the service plan objective, (e.g., AA group, assistance from IEP team at the person's school). Additionally, it is important to identify strengths the person has to motivate himself or herself to achieve the goal, including outside supports such as a neighbor or probation officer who has been identified in the assessment.

Discharge Plan: Like the rest of the Service Plan, the discharge plan is a living plan that can be changed as appropriate to the person's situation. The discharge plan should be brief and understandable to the person/family. While in theory discharge planning should begin at intake, if the Clinical Liaison feels a reasonable discharge plan cannot be formulated on the first service plan, then it should be completed at a later date.

Signatures: It is important that the Clinical Liaison ensures that the person/guardian signing the Service Plan, clearly understands what is being agreed to and how they will achieve these goals within a reasonable amount of time (target date for meeting objectives). Per the federal Balance Budget Act regulations, the person/guardian must indicate whether they agree or disagree with the service plan and the types and levels of services included. If the person/guardian checks no, a Notice of Action (PM Form 5.1.1) must be provided to the person if the disagreement concerns a Title XIX/XXI covered service. If the disagreement pertains to a Non-Title XIX/XXI covered service and the person has been determined to have a serious mental illness, the person must be

given the Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness) PM Form 5.5.1.

The Clinical Liaison should print their name, sign, indicate their credentials/position, and date the bottom of the Service Plan, along with the behavioral health professional reviewer, if the Clinical Liaison is not a behavioral health professional. Any other individuals participating in the service planning session should also sign the Service Plan.

If the Service Plan is being completed via telemedicine, the person/family member should affix his/her original signature on the forms where appropriate. The behavioral health practitioner accompanying the person should note on the appropriate lines requiring the Clinical Liaison's signature (e.g., Tom Jones, certified professional counselor, via telemedicine) and initial. At the clinician's site, the Clinical Liaison should include a statement in his/her progress notes "Service Plan completed via telemedicine" and sign the progress note to complete the documentation process.

Review of Progress: Completion Instructions

I. Review of Progress: Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

> This section should be used to document the ongoing assessment process. Instead of making additions and deletions on the original Service Plan, the Clinical Liaison should ensure that the summary provided in this section identifies additional needs, strengths and concerns that have arisen as well as significant accomplishments and changes. The summary may also include how any additional needs that have been identified will be prioritized on the next Service Plan.

II. Current Diagnostic Summary: Describe and explain any changes in diagnoses and functioning of person:

III. Team Members Present at Plan Review Meeting (CFT Planning)

IV. Date of Next Plan Review (CFT Planning) Meeting

V. Clinical Liaison (responsible for reviewing clinical record)

_____	_____	_____
Clinical Liaison's Name (print) / Signature	Credentials/Position	Date
_____	_____	_____
Behavioral Health Professional Reviewer Name (print) / Signature	Credentials/Position	Date

ANNUAL BEHAVIORAL HEALTH UPDATE AND REVIEW SUMMARY

Purpose

The purpose of the Annual Behavioral Health Update and Review Summary (i.e., Annual Update) is to record a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. The Annual Update is intended to highlight the person's ongoing service needs, cultural preferences/considerations for service provision, current functioning, risk factors, identify additional assessment or assessment updates that are necessary and update diagnostic information. Additionally, through the Annual Update the Clinical Liaison identifies what services and supports were, or were not, helpful in the past, as well as adjustments or changes that need to be made in the current service plan.

The person's Clinical Liaison or designee should complete the Annual Update with the person and other relevant participants present. The information gathered during the Annual Update, should assist both the Clinical Liaison and the person/family and their team in developing future treatment goals in order to meet their current needs.

The Annual Update may be especially useful for new service providers. The Annual Update is a document that highlights the critical factors that they need to be aware of when providing behavioral health services to the person/family.

Complete all fields starting at the top of the form and moving left to right across the document including: Name, Date of Birth, Client CIS ID#, Accompanying Family Member/Significant Other (Note relationship to person), Date of Current Assessment/Review, and Date of Initial Assessment/Last Review.

Specific Questions

I. Services and Treatment Summary: During the past year consider the following: medications and target symptoms response to treatment; significant medication side effects/adverse drug reactions, AIMS tests; significant medical conditions and response to treatment; significant laboratory findings; cultural preferences/considerations for service provision; other therapeutic interventions, services or supports provided and response to treatment (e.g., What helped? What did not help or made condition worse?); overall functioning over time since the last assessment; overall progress (or lack of); significant events/trauma since the last assessment/review, including any hospitalizations, arrests/incarcerations.

II. Current Status:

1. List all currently prescribed medications and dosages, including medications prescribed for other physical/medical conditions (medication, dosage and frequency).

2. List all other therapeutic interventions/services/supports currently utilized:

3. Describe person's current overall functioning and progress in reaching treatment objectives: Consider functioning related to the following areas as appropriate - substance abuse/dependence; living environment; activities of daily living; educational/vocational training; employment; interpersonal relationships; social/cultural; legal/criminal justice involvement.

4. Describe any significant long-term chronic risk factors such as harm to self or others; drug withdrawal or overdose/toxic use; nutrition or exposure to the elements; exploitation, abuse, or neglect.

III. Current Diagnostic Summary

1. **Axis I**: (DSM-IV TR Code, Diagnosis and Justification for diagnosis (es))

2. **Axis II** (DSM-IV TR Code, Diagnosis and Justification for diagnosis (es))

3. **Axis III**: Identify the person's specific medical conditions and check below the disease categories that apply.

- ☐ Infectious and Parasitic Diseases (001-139)
- ☐ Neoplasms (140-239)
- ☐ Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- ☐ Diseases of the Blood and Blood-Forming Organs (280-289)
- ☐ Diseases of the Nervous System and Sense Organs (320-389)
- ☐ Diseases of the Circulatory System (390-459)
- ☐ Diseases of the Respiratory System (460-519)
- ☐ Diseases of the Digestive System (520-579)
- ☐ Diseases of the Genitourinary System (580-629)
- ☐ Complications of Pregnancy, Childbirth, Puerperium (630-676)
- ☐ Diseases of the Skin and Subcutaneous Tissue (680-709)
- ☐ Diseases of the Musculoskeletal System and Connective Tissue (710-739)
- ☐ Congenital Anomalies (740-759):
- ☐ Certain Conditions Originating in Perinatal Period (760-779)
- ☐ Symptoms, Signs, and Ill-Defined Conditions (780-799)
- ☐ Injury and Poisoning (800-999)

4. **Axis IV** (Psychosocial or Environmental Stressors)

5. **Axis V** (GAF or CGAS score)_____

IV. Recommendations for Current and Ongoing Service/Treatment:

1. List prior goals that have not been achieved that still need to remain a focus of services/treatment.

2. List any new goals for the service plan.

3. List other ongoing needs or concerns that need to be addressed, including coordination of care with PCP.

4. Identify any areas in the assessment that need to be reassessed due to significant changes, e.g., person's condition, living environment, support structure.

Signatures: The Clinical Liaison should print their name, sign, indicate their credentials/position, and date the bottom of the Annual Behavioral Health Update and Review Summary, along with the Behavioral Health Professional Reviewer, if the Clinical Liaison is not a behavioral health professional, and indicate any agency affiliation.

_____	_____	_____
Clinical Liaison's Name (print) / Signature	Credentials/Position	Date
_____	_____	_____
Behavioral Health Professional Reviewer Name (print) / Signature	Credentials/Position	Date

_____

Agency

REMINDER: All demographic data reported to ADHS/DBHS must be reviewed during annual update. Based on this review:

- At a minimum the following demographic/clinical data fields must be reported to ADHS/DBHS regardless of

whether they have changed since the last data submittal: Diagnosis related information (Axis I, II, V and GAF/CGAS, behavioral health category, employment and educational status, primary residence, number of arrests since the last data update and primary and secondary substance use; and/or

- All other demographic information that has changed (e.g., other agency involvement, income for non-Title XIX/XXI eligibles).

APPENDIX A: ADHS/DBHS BEHAVIORAL HEALTH CLIENT COVER SHEET

Name_____ DOB_____ Client CIS ID#_____
Address _____ Client SS#_____
City_____ State_____ Zip _____ AHCCCS ID#_____
Phone_____ E-Mail_____ AHCCCS Health Plan_____
Gender: □ Male □ Female Primary/Preferred Language_____

Special Needs:

Interpreter	□ No	□ Yes, specify language_____
Mobility Assistance	□ No	□ Yes, identify assistance needed_____
Visual Impairment Assistance	□ No	□ Yes, identify assistance needed_____
Hearing Impairment Assistance	□ No	□ Yes, identify assistance needed_____
Need Childcare Arrangements	□ No	□ Yes, identify need_____

Due to cognitive impairments requires special assistance to participate in the assessment/service planning process. □ No □ Yes

Key Contacts:

PCP/Physician: _____ Phone_____ Fax_____
PCP/Physician Address: _____
Legal Guardian: _____ Phone_____
Custody: □ Sole □ Joint □ Ward of Court (DES Legal Guardian)_____
Parent(s)/Step Parent(s) _____ Phone_____
_____ Phone_____
_____ Phone_____
Emergency Contact: _____ Phone_____
Address_____

Other Key Contacts (e.g., school, probation/parole officer, other involved agencies (CPS, DDD), neighbors, grandparents):

Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____

Insurance Coverage: □ Medicare □ Private (self-pay) □ TriCare □ Blue Cross □ HMO □ Other □ None

Insurance Co_____ Insurance ID #:_____ Policy No:_____
(Attach copy of insurance card)

Individual Completing Form and Title:_____ Date_____

APPENDIX B: ASSESSMENT AND SERVICE PLAN CHECKLIST

Name_____ Date of Birth_____ Client CIS ID#_____
Accompanying Family Member/Significant Other (note relationship to person):_____
_____

Part A: Behavioral Health and Medical History Questionnaire (may be completed by person/family prior to first interview) **Pages 2 - 5**

☐ Completed by person prior to initial interview
☐ Completed during interview by assessor

Part B: Core Assessment (must be completed at this initial interview) **Pages 6 – 15**

- Presenting Concerns
- Behavioral Health / Medical History
- Criminal Justice
- Substance Related Disorders
- Abuse/Sexual Risk Behavior
- Risk Assessment
- Mental Status Exam
- Clinical Formulation and Diagnoses
- Next Steps/Interim Service Plan

Part C: Addenda (may be completed at subsequent appointment) **Pages 16 - 26**

Indicate below, which of the addenda you as the assessor have completed on the person during this interview

Yes	To Be Done Later	Not Applicable	Name of Addendum
☐	☐	-------	Living Environment (For all persons)
☐	☐	-------	Family/Community Involvement (For all persons)
☐	☐	-------	Educational/Vocational Training (For all persons)
☐	☐	☐	Employment (For persons 16 years and older and others if pertinent)
☐	☐	☐	Problem Gambling Screen (For persons 16 years and older)
☐	☐	☐	Developmental History (For all children or for adults who have developmental disabilities)
☐	☐	☐	Criminal Justice (For persons with legal involvement)
☐	☐	☐	Seriously Mentally Ill Determination (For persons who request SMI determination or have SMI qualifying diagnosis and GAF score 50 or lower)
☐	-------	☐	Child Protective Services (used for 24 hour urgent response for children removed by Child Protective Services)
☐	-------	☐	Special Suicide Risk Assessment (For all persons in crisis situations)

Part D: Behavioral Health Service Plan (may be completed at subsequent appointment) **Pages 27 - 28**

☐ Completed at initial interview ☐ Will be completed later

Part E: Annual Update **Pages 29 - 30**

_____ _____ _____
Assessor's Name (print) / Signature Credentials/Position Date

_____ _____ _____
Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

_____
Agency

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Person Name:	Date of Review:	
Assessor/Credentials:	Supervisor/Credentials:	

Select from:
Y = the assessment/service plan meets the standard **N** = the assessment/service plan does NOT meet the standard or **NA** = the standard is not applicable.

Directions: The Supervisor should provide comments that justify ratings. Information should also be documented that acknowledge areas in which the assessor excelled, as well as providing specific recommendations for improvement. The supervisor should also evaluate whether the assessor was flexible in their approach by adjusting or adding questions based on the individual being assessed or if a particular section was not completed documenting rational for the delay.

Standard / Item **The record includes documentation that:**	**Y**	**N**	**N/A**	
1) The Core Assessment is sufficiently comprehensive to identify the immediate needs and strengths of the person.				To qualify as a sufficiently comprehensive assessment, the assessor must be able to identify and develop functional treatment recommendations based upon the assessment including assessment of areas a-i. If any areas are absent or inadequate the assessment is not sufficiently comprehensive. Using clinical judgment, make a determination if the assessment includes enough information to identify and prioritize the services the person needs to meet their behavioral health needs.
a) Presenting Concerns				Determine whether the assessor elicited information on the immediate concerns of the person and/or his/her family and the reasons behavioral health services are being requested. Is there documentation (if possible in the person's own words) what they hope to accomplish through their engagement with the behavioral health provider. Information should include why services are being requested at this time, the duration of the persons' concerns, the specific motivations that lead to the request for services and how these factors are affecting the person's life. In addition, the desired outcomes and by what factors the person would measure satisfaction with the services they receive. The information obtained in this section provides a context to develop both service and discharge planning. The supervisor should determine whether additional probing questions that were necessary for clarification were asked.
b) Behavioral Health and Medical History (see Additional Assessments documents)				The Behavioral Health and Medical History Questionnaire collects information about 1) a person's current and past medical concerns and treatment and 2) any prior behavioral health services the person and his/her family has received or is currently receiving. The assessor should have explored past and current behavioral health history and that of their family in order to formulate a comprehensive understanding of behavioral health needs. Referrals to a PCP must be considered whenever concerns about these issues arise. The assessor should have reviewed the completed Behavioral Health and Medical

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard / Item The record includes documentation that:	Y	N	N/A	
				History Questionnaire with the person/family to verify information and clarify any items that are unclear. If the person does not have the opportunity or is unable to complete the Questionnaire prior to the interview, the assessor should have assisted the person in completing the Questionnaire as part of the Core Assessment.
c) Criminal Justice				The supervisor should assess whether adequate information was collected in the Criminal Justice section to identify those persons who are currently or have had previous involvement with the legal system (e.g., legal issues, probation, arrests, parole, court-ordered treatment). For those with involvement with the legal system, the Criminal Justice Addenda will need to be completed at some point during the assessment process.
d) Substance Related Disorders				The supervisor should determine whether adequate information was collected in the Substance Related Disorder section to identify those persons who may be involved with alcohol or substances. For persons identified with a substance use concern, enough information should have been elicited from the person and/or family to assess the following two areas: ▪ **Current and Past Substance Use-**Collects specific details about current and past patterns of use, loss of control and other DSM criteria. ▪ **Relapse and Recovery Environment-**Assesses a person's current degree of relapse risk and identifies the level of support necessary for sustained recovery. Adequate information should be obtained to establish a DSM diagnosis for abuse/dependence as well as elicit information for designing a mix of settings and services that will support long-term sobriety and recovery. If the person required additional engagement, the supervisor should determine whether the assessor repeated or revisited this as the person becomes more trusting and engaged in services. The supervisor should probe to assess whether motivational interviewing techniques, as appropriate, were utilized in the assessment and treatment planning process.
e) Abuse/Sexual Risk Behavior				The assessor should have collected enough information to determine the safety of the person's home environment and the risk of physical, sexual or emotional abuse.

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard / Item The record includes documentation that:	Y	N	N/A	
				The supervisor should assess whether the assessor gauged these questions against a person's verbal and non-verbal responses and, when necessary, adapted their interviewing methods appropriately. The supervisor should consider whether the assessor considered the need for additional engagement around these issues and whether the assessor considered the need to refer the person to a specialty provider.
f) Risk Assessment				The supervisor should determine whether the assessor was able evaluate the person's over all ability to be safe in the community and to assess the need for immediate intervention (voluntary or involuntary), balancing all known factors. Factors that should have been considered include risk/intent to harm, available supports, the existence of a safe and supportive environment, level of cognitive functioning, level of impairment from physical factors, and the presence of substance use.
g) Mental Status Exam				The supervisor should determine whether the assessor clearly documented his/her observations and impressions of the person at the time of the Core Assessment interview including a description of the person's speech, appearance, activities, thoughts and attitudes during the interview process.
h) Clinical Formulation and Diagnosis				The supervisor should determine whether the specific symptom(s) or indication(s) for which the diagnosis (es) is documented. If the symptoms and rationale for each are documented, answer YES. If there is no documentation of the symptom(s), answer NO.
i) Next Steps/Interim Service Plan				The supervisor should evaluate the type of service, urgency of service provision and frequency of service provision. All immediate needs (health, safety and security) needs identified in the assessment plan must be addressed to qualify for a YES answer unless there is an adequate justification for delay. If none are identified or only some of the needs that are identified in the treatment/service plan are-addressed, mark answer NO.
2) All applicable Assessment Addenda been completed and contain ample information to assess the strengths and behavioral health needs of the person:				The supervisor should determine whether the assessor thoroughly completed the addenda developed for specific population groups (e.g., SMI Determination, Developmental History, etc) based on the trigger questions. If not completed at the initial interview, the assessor should indicate which additional Addenda will be completed at a later date or are not applicable.
a) Living Environment (for all)				The supervisor should determine whether the assessor collected adequate information to gain an understanding about the support system the person has developed, his/her day-to-day stressors, and how he/she copes with activities of daily living. If securing a safe and appropriate living environment was identified as a need, the assessor should have included this as a priority for service

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard / Item The record includes documentation that:	Y	N	N/A	
				planning.
b) Family/Community Involvement (for all)				The supervisor should determine whether the assessor collected adequate information to understand the person outside of the symptoms and the diagnostic checklists (such as who the person is - in his/her relationships and in his/her culture and about trust and perceptions of self). The assessor should have identified the person's strengths, which then need to be built upon and included in the service plan as well as emphasized to facilitate hope for recovery and change.
c) Educational/Vocational (for all)				The supervisor should determine whether the assessor collected adequate information to assess other areas in the person's life where there may be either success or difficulty. The area of education or vocational training often reveals strengths, skills and interests as well as long-range goals. The assessor should have probed into what the person does all day and utilized information gathered to identify possible collaborators, supports and resources.
d) Employment (for persons 16 years and older)				The supervisor should determine whether the assessor completed this addendum consistent with expectations (only be completed on persons who are 16 years of age or older or if pertinent for persons who are younger). The assessor should have collected enough information to gain an understanding of the person's ability to hold a job, their attitude about working and the overall impact that employment has on the person's life. The assessor should have identified strengths and difficulties getting, keeping or tolerating employment or the ability to function in some settings and not others may be identified. Information collected should have been used in diagnosis and service planning.
e) Developmental History (for all children and for adults with developmental disabilities)				The supervisor should determine whether the assessor completed this addendum consistent with expectations (all children and for adults who have developmental disabilities). The supervisor should determine whether the assessor collected adequate information to understand and document key elements of the person's social, emotional and physical skill development. The assessor should have considered and incorporated the information in: ▪ Identifying possible developmental problems and the need for further diagnostic evaluation. ▪ Providing an objective description of a person's abilities and deficits. ▪ Determining the need for other programs e.g., developmental disability services. ▪ Assisting in planning for appropriate interventions.
f) Criminal Justice (for persons with legal involvement)				The supervisor should determine whether the assessor collected adequate

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard / Item **The record includes documentation that:**	Y	N	N/A	
				information to understand the criminal justice history and/or current trouble with the law for those persons identified in the Core Assessment as having involvement with the legal system. The assessor should have explored the situation and factors that may have contributed to the person's actions (e.g., substance use, peer pressure, economic factors).
g) SMI Determination (for persons who request SMI determination or have SMI qualifying diagnosis and GAF score 50 or lower)				The supervisor should determine whether the assessor completed this addendum on the appropriate persons. The assessor should have utilized the information collected throughout the assessment to promptly and accurately identify persons with a serious mental illness (SMI).
3) The Service Plan reflects the balance of strengths and needs identified in the assessment. The appropriate covered services and supports are included based on the persons needs as identified in the Core Assessment and Addenda.				This is an overview question that is scored based on the following: The supervisor should evaluate <u>the type of services/supports</u> (including specialized services) included on the service plan. Prioritized needs identified in the assessment must be addressed in the service plan to qualify for a YES answer. If none are identified in the service plan, mark answer NO. Review the services as related to the needs identified in the assessment and treatment recommendations. If the person is receiving services with sufficient frequency to implement the service plan recommendations or clear attempts are being made to engage the person or adjust the service plan as necessary, answer YES. If no evidence is present, answer NO. For persons who are capable of managing their own services, case management services may not be necessary. If the person does not appear to need case management services and was not receiving services, answer YES. All components of the service plan must have a clear plan for implementation including who is providing the services/supports (name, address and phone number), when services are to begin and frequency of service provision) or outline the steps to be taken in securing the needed services to qualify as a YES answer.
4) The Service Plan reflects the priorities, values and desires of the person and family.				Review the Service Plan and decide if the identified needs of the person are incorporated into the plan.

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard/Item **The record includes documentation that:**	**Y**	**N**	**NA**	
5) The person, involved family members (Parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family), and other involved parties are invited to participate in the service planning process: a) Family Member				If, in the service planning process, there is evidence that staff have made efforts to actively engage the person, involved family members/significant others, or other involved parties/agencies in the treatment planning process, answer YES. If there is evidence that these individuals would have an impact on service planning but there is no evidence of staff efforts to engage them, the reviewer will check the NO box assigned to the designated person (individual, family/significant other, other agencies). Answer NA if there are no family/significant others or other agencies. Since an adult person has to give permission for other involved parties or family members to participate in service planning, this should be considered when deciding who should have been involved. For each person or agency designated, evidence of active engagement includes verbal or written efforts to solicit their input.
b) Clinical Liaison				A Clinical Liaison is a behavioral health clinician who is credentialed and privileged and whose primary responsibility is to provide clinical expertise to the person's Team and to serve as a point of contact and communication, while working in congruence with the team process. Each person must be assigned a Clinical Liaison. Answer NO if there is only a designation of a person as the Clinical Liaison without any evidence of their involvement in the service planning process described above. Answer YES if it is evident that the Clinical Liaison is playing an active role. Answer NA if standard 7 was answered NO.
c) Psychiatrist/NP/PA				
d) Nurse				
e) Other professionals (if appropriate)				
f) Vocational Rehabilitation Specialist (if appropriate)				
g) Parole/Probation Officer (if appropriate)				
h) School Official (if appropriate)				
i) Advocate/Designated Representative (if appropriate)				
j) Involved Providers of Service				

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard/Item **The record includes documentation that:**	**Y**	**N**	**NA**	
k) Representatives from other State Agencies (if receiving services from that State Agency)				For persons with multi-agency involvement, there should be evidence for each agency identified that staff actively attempted to engage their participation and that their input was considered in the development of the treatment/service**.** For each individual or agency designated, evidence of active engagement includes verbal or written efforts to solicit their input. For persons with multi-agency involvement, if evidence of active engagement to solicit input from **all** designated parties is present, answer YES. If no evidence of active engagement, or that only **some** of the designated parties were solicited for input, answer NO.
6) The person's (and family's) cultural preferences and language needs are assessed, considered, and incorporated into the person's Service Plan.				The person's preferences should be identified to further customize treatment to his/her unique cultures, faith, traditions and priorities. If there is an indication that the person's or family's cultural preferences were assessed, considered and incorporated into the person's treatment recommendations, answer YES. If not, answer NO. If the person's or family's cultural preferences were assessed but
7) The Service Plan is appropriate to the acuity of the person's condition.				The supervisor should determine whether services were provided in a time frame responsive to the urgency of the person/family's need. For example, conditions requiring emergency response/attention may include acute withdrawal, acute psychotic symptoms that present an imminent risk with suicidal or homicidal ideation with intent, plan or means or an acute change in behavioral symptoms such as increased aggression or behavioral changes with imminent risk of loss of job, home, or property destruction, etc. If services were provided in an appropriate timeframe, answer YES. If services were not provided in an appropriate timeframe, answer NO. N/A is not permitted.
8) The assessor assisted the person to develop clear, person-centered objectives using language that is easily understood by the person/family for the Service Plan.				Objectives may focus on areas of functional improvement (e.g., improved job or school performance, ability to perform activities of daily living, increased social activities, improved interpersonal relationships, etc.), symptomatic improvement, (e.g., decreased hallucinations, mood swings, harmful behaviors, substance abuse, etc.) or personal improvement/achievements (e.g., weight loss, relationship, etc.).

APPENDIX C: SUPERVISOR'S ASSESSMENT AND SERVICE PLAN REVIEW STANDARD

Standard/Item **The record includes documentation that:**	**Y**	**N**	**NA**	
				The supervisor should review the Service Plan for measurable objectives, which address the identified needs. If no measurable objectives are present or if there is no Service Plan, answer NO. If objectives are present, review to determine whether the objectives address the identified needs in the Service Plan. If the objectives both address the identified needs and are measurable, answer YES. If the objectives are present but not measurable, or do not address identified needs, answer NO.
9) The method of the Service Plan has sufficient detailed regarding who when and what will be done. .				The supervisor should review the Service Plan for methods (action steps) that are based on the objectives. Methods are the specific action steps or means that are needed to obtain the objectives. If there are specific methods identified in order to accomplish the objectives, answer YES. If there are no methods identified in order to accomplish the objectives, answer NO.
10) The next appointment was scheduled within 23 days of the intake or sooner based on the urgency of the person's needs.				
11) The Service Plan identifies persons who based on the presenting problems need to see a psychiatrist and the first psychiatric appointment is scheduled.				If the assessment reveals the need for further assessment by a psychiatrist, the Service Plan contains provision for a psychiatric appointment.
12) Cultural preferences of the person are honored in the service plan.				The supervisor should determine if consideration was given to cultural strengths of person/family that can be used in service planning.

APPENDIX D: BEHAVIORAL HEALTH SERVICE PLAN

Name: Ralph Magee CIS Client ID# REM 4000 Program: SMI Today's Date: 8/25/03

Individuals at Service Planning Meeting: Ralph Magee; Maxwell Jones, Clinical Liaison; Mrs. Magee, Mother; Mr. Magee, Father; Adriana Smith, CM; Willow Martinez, Rehab Specialist; Carrie McGuire, RN; Ed Vance, Team Lead and Sandy Baker, Housing Specialist

RECOVERY GOAL/PERSON-FAMILY VISION: Ralph wants to increase his independence and social activities: I want to have my own apt (or share one with a friend), n my sobriety and have a job that I like (using my hands).

PERSON'S STRENGTHS: Ralph is motivated, sober, has good basic independent living skills (ILS, within current living arrangements with family, likes to build model airplanes and is good with engines, has his own bank account, knowledgeable of the bus system, worked part time previously, has transferable job skills, attends church with family and found Latino AA Groups to be beneficial in the past.

Review Date (Objective Target Date): 9/28/03

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
1 Maintain sobriety, re-contact and attend AA Group.	0	Participate in individual counseling 2x per month and Group Counseling 1x per month. Attend 1 AA Group per week	Latino AA Group Sponsor Motivation	2/month 1/month 1/week		
2 I want to have my own or shared apartment, (apply for Section 8)	0	Work with CM to obtain and complete application	CM (Adriana) Housing (Sandy) Interest	1		
3 Apply for part time job. Go to One-stop Center, fill out 4 applications.	0	Meet with RSA Go to One-stop Center	CM/RSA Transferable skills Motivated	4		

DISCHARGE PLAN (add discharge date if known):

Person / Guardian _____ Date:_____

☐ Yes, I am in agreement with the types and levels of services included in my service plan. ☐ No, I disagree with the types and/or levels of some or all of the services included in my service plan. By checking this box, I will receive the services that I have agreed to receive and may appeal the clinical team's decision to not include all the types and/ or levels of services that I have requested. *

Clinical Liaison_____ Date:_____ Other_____ Date:_____

BH Prof. Rev._____ Date:_____ Other_____ Date:_____

*If no is checked, a Notice of Action (PM Form 5.1.1) must be provided to the person if the disagreement concerns a Title XIX/XXI covered service. If the disagreement pertains to a Non-Title XIX/XXI covered service and the person has been determined to have a serious mental illness, the person must be given the Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness) PM Form 5.5.1.